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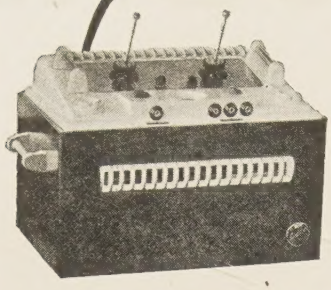

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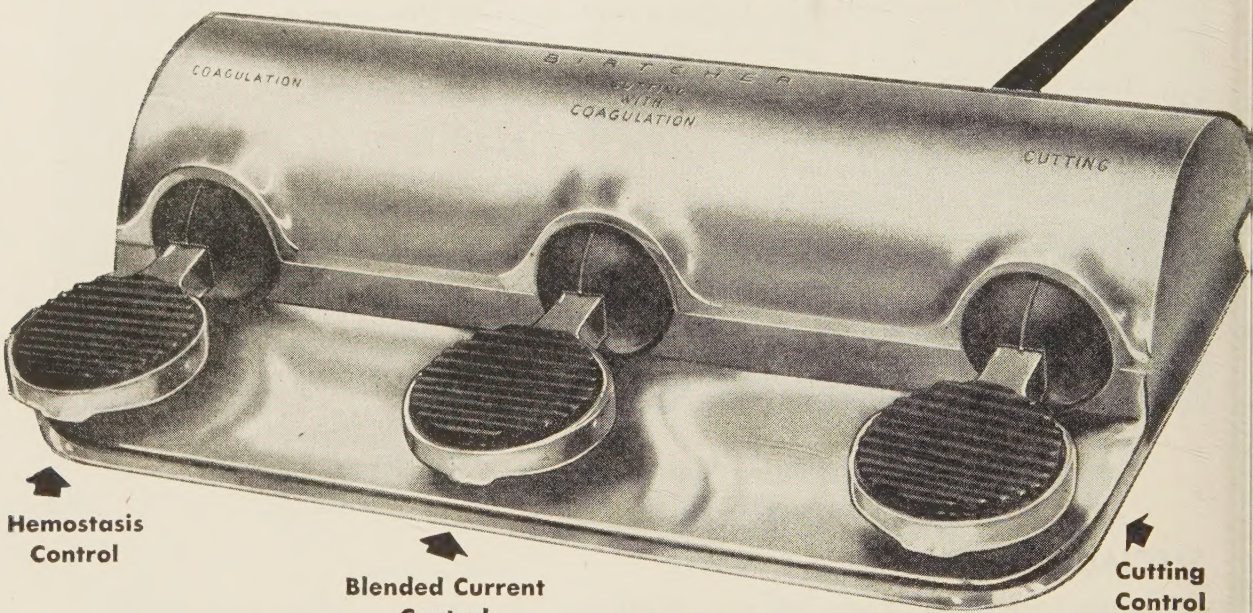

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Suicides in Wartime

It is a familiar fact that suicides decline during wartime, says the *Statistical Bulletin* of the Metropolitan Life Insurance Company (July 1944), and the experience in the present war shows the usual trend. In 1942 and 1943 the suicide rate among the Metropolitan policyholders was lower by about one-fifth than that for the preceding three years. In 1943 the suicide death rate among these insured established a new low record and so far in 1944 the indications are that the toll from suicide is still further being reduced. The general pattern of the reduction is quite different for the two sexes. Among white male policyholders the decline in 1942 and 1943 amounted to almost one-fifth at the age period of fifteen to twenty-four; the decline increased with advance in age, and at the older ages amounted to about one-third. It is noteworthy that the greatest relative declines among these men were made at the period of life where the toll from suicide is heaviest.

Among white women the greatest percent of decline occurred at the younger ages where the suicide rates are at their lowest. In the age period fifteen to twenty-four, the only ages at which the relative decrease for females exceeded that for males, the reduction amounted to about one-third; at twenty-five to thirty-four it was one-fifth. At most ages beyond thirty-five years, the saving of lives among white women was quite negligible.

The general decline in the suicide rate in recent years may be attributed to the prevalence of economic conditions and to the psychological effect of the war. The sharp decrease has probably been due for the most part, to the opportunities for employment at relatively high wages. The economic factor has also no doubt played a large rôle in reducing the suicides among adolescent girls and young women. Psychological factors have likewise been operating to reduce the toll from suicide. The subordination of petty personal considerations to the broader needs of the nation at war have had a general salutary effect. However, even now suicide takes considerably more than thirteen thousand lives a year in the United States. It is hoped that psychiatry, with the experience it has gained in the war, will be able to make a valuable contribution toward this end.

National Chemical Laboratory for India

A plan for the establishment after the war of a National Chemical Laboratory for India to specialize in industrial research and to develop new processes has been drawn up by the Council of Scientific and Industrial Research at Delhi, according to *Science*. Emphasis will be laid on industrial research and the development of new processes up to the pilot plant stage, so that the chemical industry and other industries requiring the aid of chemical research in general will benefit from the investigations carried out. It is proposed that the laboratory should provide accommodation and facilities for the following main branches of chemistry: inorganic chemistry, including analytical investigations; organic chemistry, including drugs and chemotherapy; physical chemistry, including high-pressure technique and electrochemistry; biochemistry, including biological products and chemical engineering. The workshops and pilot plant equipment suggested for the laboratory should enable it to undertake any type of industrial research.

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Open Forum

Peace and the Doctor

SOLOMON R. KAGAN
Roxbury, Mass.

Scientists in general and physicians in particular have been thrust by the urgent necessities of warfare into activities of decisive importance. To the medical man is assigned not only the responsibility of selection of the men competent physically and psychologically for combat, but also for the medical care of these men, injured or ailing, in the front line, at the bases and in the training camps. In addition, to them is allocated the task of supervising public health, and the prevention and control of epidemic disease, wherever the American flag is unfurled. Meanwhile, scientists and creative research workers labor to improve the weapons of offense and defense employed against the enemy on land, sea, and in the air, as well to develop secret new devices which will help to establish the supremacy of our armed forces. On the other hand, statesmen, political leaders act mainly in wartime to maintain morale and production on the home front and as coordinators between the allied nations. In past wars, as soon as hostilities were ended physicians and scientists were eliminated as important factors, and the statesmen and diplomats took over complete leadership in the negotiations and conclusion of treaties. Unfortunately, as can now be clearly recognized, this practice has been one of the chief contributors to the recurrence of wars.

The responsibility for instigating wars lies on th shoulders of the people as well as of their leaders. Th masses still tend to the settlement of their racial dif culties by brute force. There is an abyss between i tranational and international morality based on egoi tic principles and lack of enlightment. However, th most important causative factor in war is the failure the statesmen, diplomats, and political leaders, the i ternational industrialists and business men to hand properly the final settlements at the peace table. State men who have directed the policies of nations have al been guilty of gross neglect in the preliminary or pr ventive stages of disastrously playing appeasement po tics. Their failures prove that they were lacking in th necessary breadth of vision and the basic scientific u derstanding of human psychology, philosophy and hi tory.

In order to avoid the blind errors of past war settl ments, men of wider vision and broader experience wi humanity, such as the physician, psychologist, ps chiatrist, scientist, criminologist, historian, economi and educator, should have a place at the peace confe ences. These men of science know the psychology of th various races, their national traits, aspirations a traditions, and accordingly could be of enormous a sistance in arriving at practical conclusions in the for of effective treaties, which alone can establish perm nent peace and international understanding. Our en mies, Germany and Japan, have always leaned heav on their scientific personnel.

The rôle of the physician at the peace table after th present war is particularly indicated inasmuch as w have to deal with recognized aberrations and abn

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malities. It is an established fact that the Germa killed, during the current war, several millions of m women and children—not for strategic reasons, but the mere sake of "killing". There is, as well, ample e dense that they tortured many millions of human ings out of pure and primitive sadism. The Germa invention of mass "killing vans", where old and you human beings are suffocated by gas in closed trucks, well as the German practice of a mass castration groups of innocent and normal men and women wh they dislike, deserve the study of psychiatrists and cr inologists. These brutal facts testify to the psyc pathic mind, to the pathological behavior and to moral degeneration of the German people. As a man is isolated under the physician's observation and c trol, so a pathological nation should be strictly di plined and controlled under a physician's direction is a medical problem and should be handled as su Physicians and surgeons have had experience in fig ing pathogenic microorganisms by such potent w pons as disinfectants, serums and vaccines. It is lik they can work out some effective remedy in this fi against the psychopathic and aggressive macroorg isms—the Germans and Japanese—and develop a quate techniques for political disinfection and milit sterilization.

It is noteworthy to register that the Germans burn up and wantonly destroyed forward-looking bo written by humanitarians and liberals on brotherho fraternity and human rights, while they inspired a manufactured literature directed against freed religion, masonry and labor unions. This represent perverted and pathological attitude, and needs med interpretation and treatment. The full correction such a tendency will require forced reeducation of Germans over two or three generations, if we intend preserve civilization and humanitarism, and to prese international law and order.

It is of great interest to note the opinion of seve outstanding physicians and surgeons on the problem war and peace with Germany. Sir William Osler (18 1919), of Cambridge University, the leading physic of his time, wrote in 1917 that "the military spirit the German nation is a menace to the world's peace a civilization". Dr. Harvey Cushing of Yale Univers world-famed brain surgeon, remarked that Osler wo make a good director of propaganda during the war may be added that he would also have made a valua advisor at the peace table on how to destroy the b baric German military spirit and their patholog superiority complex.

Colonel Fielding H. Garrison (1870-1935), of Wa ington, D.C., the greatest American medical histori wrote in 1921:

"I have never seen Wickersheimer [eminent Fre medical historian] in the flesh, but like other Fre physicians I have met recently, he looks as if recent murmurs in Germany had scared him to death. T Ludendorff creature ought to be captured and c demned to amputation of the head at the neck or bisection of the body by a single sword-stroke verti ly, like the Carthagianian general at the end of Fl bert's Salammbo. A defeated general should live up his defeat manfully and honorably, as General Lee a Admiral Maury did after Appomattox. The Pruss saber-rattlers will bear watching for a long time come, I fear" (1).

Professor Jacques Loeb (1859-1924), former h

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of the department of experimental biology at the Rockefeller Institute for Medical Research, New York, wrote in 1917:

"If we succeed in substituting for the present a new type of statesmen who are familiar with and follow the development of the exact, i.e., the experimental and quantitative sciences, and who are willing and capable of applying the results of exact science to the intellectual, moral, physical, and economical uplift of the masses, we shall at least diminish the danger of war." (2)

Dr. William S. Halsted (1852-1922), former professor of surgery at the Johns Hopkins University School of Medicine, in a personal letter to Colonel F. H. Garrison in 1917, wrote:

"The ethnological studies of Dr. Welch [William H. Welch, of Johns Hopkins University, the great American pathologist] have convinced him [Colonel McCullogh] that the Germans necessarily are barbarians. I find it very hard to illustrate my paper with portraits of the Germans. Possibly I shall have to discard them." (3)

Dr. Samuel J. Meltzer (1851-1920), a great American physiologist, organized in 1915 the Medical Brotherhood for the Furtherance of International Morality. He expressed the opinion that reeducation of nations could prevent wars, and that medical men are in a position to contribute much to the world's peace and order (4).

It is very likely that the cooperation of the physician, psychologist, historian, economist, with the diplomats and statesmen at the peace table might result in effective measures for routing out the "German danger" to the world's peace. By achieving the vital goal, the main global center of infection with militarism and war psychology will be removed, and a permanent peace be promoted. The bacteriologists, pathologists and hygieists by their extensive labors have effectively benefited mankind. The time has arrived when scientists should organize to take the lead in applying their scientific methods to this new field, the field of saving humanity and civilization from the reactionary willfulness and tyranny by barbaric and aggressive nations.

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1. Kagan, S. R.: *Life and Letters of Fielding H. Garrison* Medico-Historical Press, Boston, p. 149.
2. Loeb, J.: *Science* 45:76, 1917.
3. Kagan, S. R.: *Physicians Letters.* Medical Record 157:492 (August) 1944.
4. Meltzer, S. J.: *Science* 41:515-523, 1915. See F. H. Garrison's *History of Medicine,* pp. 815-817, 1922.

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Typhus Commission Medal Awards

The United States of America Typhus Commissi Medal has been awarded by order of the President Dr. Abdel Wahed El Wakil, Egyptian Minister Health, and to three British Brigadiers of the Roy Army Medical Corps for the help they have given re resentatives of the Commission in investigating typh fever in the Middle East and southern Italy. The mer bers of the Royal Army Medical Corps are Brigadie John S. K. Boyd, George B. Parkinson and Rudolf W Galloway. Dr. Waki was cited for his close cooperati with the Commission at Cairo which resulted in bene to the military forces; Brigadier Boyd's citation w for his cooperation in arranging for the distribution typhus vaccine through the Middle East; and Brigadi Parkinson and Galloway were cited for their help preventing the spread of typhus in southern Italy.

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Filariasis in the White Man

H. Neumann, medical officer in Western Samoa, says (*Jour. Trop. Med. and Hygiene,* June-July, 1944) that the problems of filariasis gain new importance on account of the vast number of white people exposed to infection and necessarily many cases of filariasis will be seen in temperate climates in persons returning from endemic areas. While the disease occurs in all tropical countries, he continues, it is most prominent in the central Pacific islands, where malaria is absent. In these islands the majority of the native population is affected and the incidence of filariasis among white people is higher than in any other area. A considerable percentage of temporary residents will, under unfavorable conditions, become infected, and show symptoms of early filariasis, but some persons never present symptoms even when heavily infected. Even microfilaria carriers, who have lived in endemic areas for many years, may never have had any noticeable symptoms.

If symptoms do arise they can be classified as belonging to one of three types, namely, the allergic, the streptococcal superinfected, and the staphylococcal superinfected types. In the allergic type of early filariasis, there is a diffuse edematous swelling of a leg or an arm and the skin is dense and white; there is little or no malaise, no pain and little or no rise in temperature. Usually, no treatment is required and the swelling resolves itself. This type of early filariasis may also be localized in the scrotum. The second type of early filariasis, which is due to a superinfection by a streptococcus, occurs frequently in both natives and white people and is characterized by lymphadenitis and lymphangitis. There may be slight or high fever, with malaise, pain on touch, and swelling in the region lymph glands. The attack may last for several days a leave the patient in a debilitated state for some tim Attacks of this second type respond to treatment wi the sulfonamides, particularly if they are given early

The third type, which is found more frequently natives than in white people, is a staphylococcal supe infection with severe local pain and more localiz swelling. These attacks do not respond to sulfonami drugs and surgical treatment is indicated.

The late symptoms of filariasis, namely, elephantia and related forms of chronic lymph stasis, follow n merous attacks of the streptococcal type over yea The diagnosis of early filariasis mainly depends on t clinical symptoms that complicate the infection. T skin tests have so far been unreliable; eosinophil which is usually present, may be due to simultaneo infestation with intestinal parasites. The search f microfilariæ in the blood as a proof of infection in te porary residents in an endemic area is of no practic value because of the late appearance of the microfilar in blood samples; they are usually not found before t seventh year of infection. The only practical way preventing the disease, therefore, is protection agai mosquitoes. In wartime the necessity of camoufla makes this difficult in living areas, hence the inciden of filariasis is higher than is ordinarily the case amo white people.

The prognosis as to the later development of e phantiasis is good in the allergic and staphylococ types of filariasis, and attacks of these types do n warrant departure of the non-native patient from t area. The prognosis is also good after several attac of the streptococcal superinfected type, but the occ

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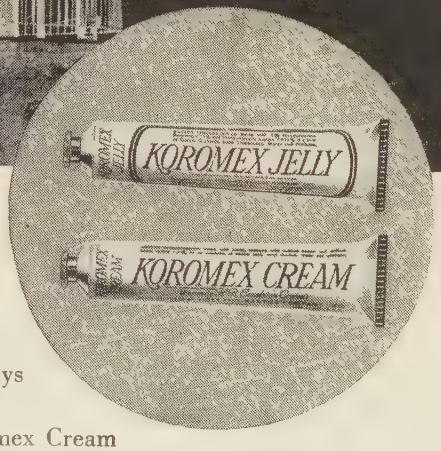

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rence in one region of three or more attacks with lymphangitis and fever should be taken as sufficient warning for casual residents to leave the endemic area.

The author points out that there is practically no danger of introducing the disease into countries of temperate climate by the return of infected patients.

The author summarizes the treatment of filariasis as follows: the first type of early filariasis does not require any treatment, the second type responds to the sulphonamides, and the third type, if not resolving spontaneously, responds quickly to surgical treatment. For late filariasis, surgical treatment is indicated for hydrocele and more localized elephantiasis, but is hardly ever required after a residence of several years or a shorter term in an endemic area.

Increased Shipments of Whole Blood

Since the designation of Boston as a whole-blood donor center in addition to New York and Washington, the shipments of type "O" blood, which the Army is flying across the Atlantic, have been stepped up to seven hundred fifty pints a day and even larger shipments are anticipated. Whole blood has always been used (in addition to plasma) for severe hemorrhage and surgical cases and up to now the source of donors in the various theaters was adequate. With increased activities in France, however, it was estimated that requirements would exceed the amount of blood available in this theater so arrangements were made for the Red Cross to collect the blood here and the Army to fly it across. This whole blood is available for transfusion in the European theater within twenty-four hours after leaving the United States.

Postwar Venereal Disease Control

A national conference on postwar venereal disease control will be held in St. Louis, Mo., November 9th to 11th. Dr. J. R. Heller, Jr., chief of the Venereal Disease Division of the Public Health Service, said that the purpose of the St. Louis conference was to bring together leading experts in all phases of venereal disease control who will determine the best methods for giving wide application to recent advances in treatment of venereal diseases.

Scientific papers will be presented by outstanding workers in the newer treatment methods. The U.S. Public Health Service, the National Research Council, and medical departments of the Army and Navy will report their findings on the effectiveness of penicillin in syphilis and gonorrhea, and recommend treatment procedures. Reports will be given on the intensive treatment of syphilis in one day to two weeks with arsenicals and by other rapid methods employed in the sixty-three special hospital units established throughout the country as rapid treatment centers for gonorrhea and syphilis. Particular attention will be given as to how the centers can be used most effectively after the war for both venereal disease control and research purposes. State and local health authorities will advise as to how the new treatment methods and facilities may be utilized best in local venereal disease control. Private physicians and hospitals will also make recommendations regarding these participating in the program. Dr. Heller will outline to the conference specific questions which have grown out of developments in venereal disease control during recent years, specific answers to which will be formulated at the conference sessions.

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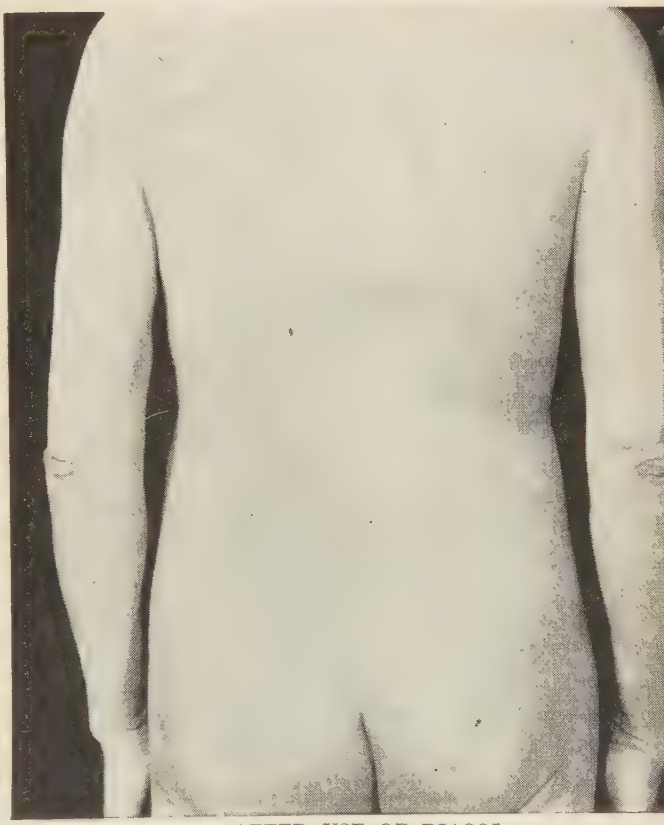

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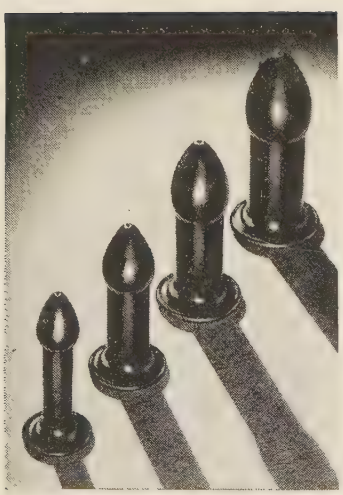

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Prolapse of the Uvea

Dr. R. Denig (*Arch. Ophthal.*, March 1944) says that in prolapse with intact uvea the sensory vasomotor reflex released by the mechanical irritation, is capable, at most, of producing increased tension in predisposed eyes. In prolapse with injured uvea there occurs a chemotactic irritation which may lead to uveitis and by metastasis of chemical decomposition products into the second eye, to sympathetic ophthalmia. The almost immediate subsidence of iridocyclitis in animal experiments is due to the primitive animal psychoreflex. Next to uveal injury and continuous uveal irritation, the vasomotor psychoreflex constitutes one of the three foundations for sympathetic ophthalmia, in that it prevents rapid extinction of the sympathetic direct and indirect reactions. Sympathetic irritation must be interpreted as a manifestation of congenitally exaggerated psychic sensitiveness by the aid of vasomotor psychoreflexes in the paired areas of the sympathetic-trigeminal ocular plexus in the region of the direct and indirect reactions. Experimentally no sympathetic irritation could be produced in rabbits by scarifications of a prolapse, repeated every third day for a period of two months, however, when a dog with a prolapse, was confronted by a cat, a mild, psychic sympathetic hypermia in the second eye was produced. Also, in primary glaucoma the vasomotor psychoreflex constitutes one of the three etiological factors. In its early stage one has to deal with a stimulus, caused not infrequently by vascular changes. Only after superimposition of the vasomotor psychoreflex on the vasomotor sensory reflex is the intraocular fluid secretion increased to such a degree that presuming an already existing or developing obstruction of the outlets of the eye, the mechanism for increased intraocular pressure is started. Treatment of uveal prolapse depends upon the intact or injured condition of the uveal tissue. Psychotherapy offers a possibility of further aid.

Penicillin Treatment of Gonorrhea May Conceal Syphilis Symptoms

Physicians of the U.S. Public Health Service, Federal Security Agency, state that penicillin used to treat gonorrhea may mask or hide the symptoms of syphilis in patients who have both diseases. Dr. C. J. Van Slyke, of the Public Health Service Venereal Disease Research Laboratory, Staten Island, and Dr. S. Steinberg, of the U.S. Marine Hospital, New York City, say that the possibility of overlooking syphilis symptoms in gonorrhea patients treated with penicillin can be avoided if special microscopic tests are made before penicillin is used, and if blood tests are made after penicillin treatment has been completed.

The masking effect of penicillin on syphilis symptoms, they continue, is due to the fact that the relatively small amounts of penicillin required to cure gonorrhea are sufficient to cause disappearance of the spirochete germs of syphilis from syphilis sores, although not sufficient actually to cure syphilis. When serum from the sores is examined under a special microscope after penicillin has been used, the spirochete germs will not be seen, and the examining doctor may conclude that the patient was not infected with syphilis. Making the microscope examination before treatment with penicillin prevents this possible error.

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Reprint available on cigarette research —Archives of Otolaryngology, March, 1943, pp. 404-410. Camel Cigarettes, Medical Relations Division, One Pershing Square, New York 17, N. Y.

Our Contributors

George H. Ryder, M.D., F.A.C.S., New York, was graduated from Yale University with the degree of A.B. in 1894, and received his degree in medicine at the College of Physicians and Surgeons, Columbia University, in 1899. He served internships in surgery at St. Vincent's Hospital, 1899-1901, in medicine at the New York Foundling Hospital, 1901-2, and in gynecology at Roosevelt Hospital, 1902-3. He was resident obstetrician at Sloan Hospital for Women, 1904-7, attending obstetrician (assistant) for one year, and has been consulting obstetrician since 1920. He has been clinical professor of obstetrics at Columbia University since 1927 and for several years consulting obstetrician to the French and Fifth Avenue Hospitals. He is a member of several local and national societies and has made numerous contributions to the literature of his specialty. His hobbies are horseback riding, swimming, boating and writing. He is a friend of artists and has collected many works of art.

* * *

Edwin W. Hirsch, M.S., Chicago, Ill., was graduated from Rush Medical College, University of Chicago, in 1916. He is a urologist, and is on the attending staff of Englewood Hospital, Chicago. His contributions to literature include a book entitled *The Power to Love,* a physiological study of regeneration.

* * *

Hans Cohn, M.D., Cleveland, Ohio, was born in Hamburg, Germany, and studied medicine at the University of Berlin, 1906-1912. Be became a licensed physician in 1912, and received his doctor's diploma from the University of Berlin in 1914. He served for four years in the first world war as an army physician in France and Russia. While in Russia he made a study of Soviet medicine. From 1918 to 1938 he practiced medicine in Berlin, during which time he was a member of the Berlin Medical Society and the Berlin Chamber of Physicians. He is much interested in bone diseases, and for some years has been engaged in research on new methods of healing bone fractures. His hobbies are gardening and reading.

* * *

Irma Cohn, M.D., Cleveland, Ohio, studied medicine in Heidelberg, Würzburg, and Munich, graduating in medicine from the University of Munich in 1913. She practiced medicine in Berlin, 1923-1938.

* * *

Richard J. Behan, M.D., F.A.C.S., F.I.C.S., Pittsburgh, Pa., was graduated from the Western University of Pennsylvania Medical School, University of Pittsburgh, in 1902, and was associate professor of physical diagnosis at the university for four years, 1904-1908. He did postgraduate work in Europe, 1910-1914, and received the degree of doctor of medicine at the University of Berlin in 1914. At present he is on the surgical staff of St. Joseph's Hospital, and the City Home and Hospital, Mayview. He served with the Red Cross during the Serbian-Bulgarian War, 1913, and was decorated by the King of Serbia. He also served in the Medical Corps of the U.S. Army during the first World War. He is the author of several books on pain and cancer, subjects in which he is particularly interested. He is a member of many local and national medical organizations, and has served these societies in an official capacity at various times. He has traveled extensively throughout Mexico, Central and South America, and the West Indies, this year's trip being his eighth annual trip to these countries. He is president of the Pan-American Cooperative Foundation.

* * *

Leo E. Grajewski, M.D., F.A.C.S., Detroit, Mich., was graduated from the University of Pittsburgh in 1912, and has been attending surgeon to the Alexander Blain Hospital and Clinic since 1913. He specialized in urology and was formerly junior attending urologist to St. Mary's Hospital and consulting urologist to St. Francis Hospital, Detroit. He is engaged in research on testicular dysfunctions.

* * *

Clifford L. Bartlett, M.D., Pasadena, Calif., was graduated in medicine from the University of Indiana School of Medicine, Indianapolis, in 1914, and served as instructor in bacteriology and pathology, University of Iowa, 1914-17. He served in the first world war both in this country and overseas. He was formerly director of laboratories at several hospitals, associate in pathology, Peking Union Medical School (Rockefeller Foundation), and special lecturer in bacteriology and pathology, Medical Department, University of Southern California. At present he is engaged in the practice of internal medicine, and is a senior medical attendant on the staff of the Huntington Memorial Hospital, Pasadena.

* * *

Bernard M. Zussman, B.S., M.D., New York, obtained his academic degree at the College of the City of New York and was graduated in medicine from the New York University College of Medicine in 1930. He is on the staff of Beth Israel Hospital. His interests other than medicine are music and tennis.

* * *

Solomon R. Kagan, M.D., Roxbury, Mass., was graduated from the University of Dorpat Faculty of Medicine, Russia, in 1917, and was formerly a member of the staff of the Jewish Memorial Hospital in Roxbury. He is the author of a number of books, including *Jewish Contribution to Medicine in America,* and has written numerous articles on medical, historical, bibliographical and literary subjects, published in the Russian, German, Hebrew, Yiddish, and English languages.

Postgraduate Assembly at Chicago Institute of Medicine.—"Nervous and Mental Diseases and War" is the subject to be discussed at the Postgraduate Assembly of the Institute of Medicine of Chicago which will be held at the Palmer House on November 1st and 2d. The program will consist of a series of panel discussions on war neuroses, battle fatigue, war injuries to the nervous system, effect of war on the behavior of the civilian population, and who are unfit for military service. Dr. Foster Kennedy, of New York, will preside at a neuropsychiatric "Information Please" program at the first evening session. At the second evening's session Dr. Edward A. Strecker, of Philadelphia, will deliver the seventeenth annual Pasteur lecture of the institute on "War Psychiatry and Its Influence on Post-war Psychiatry and Civilization".

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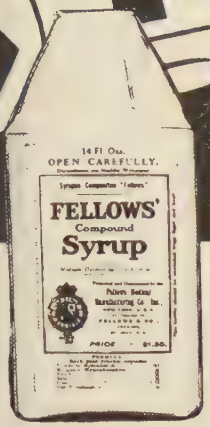

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[1] Diseases of the Skin: Sutton & Sutton, 1939, p. 99

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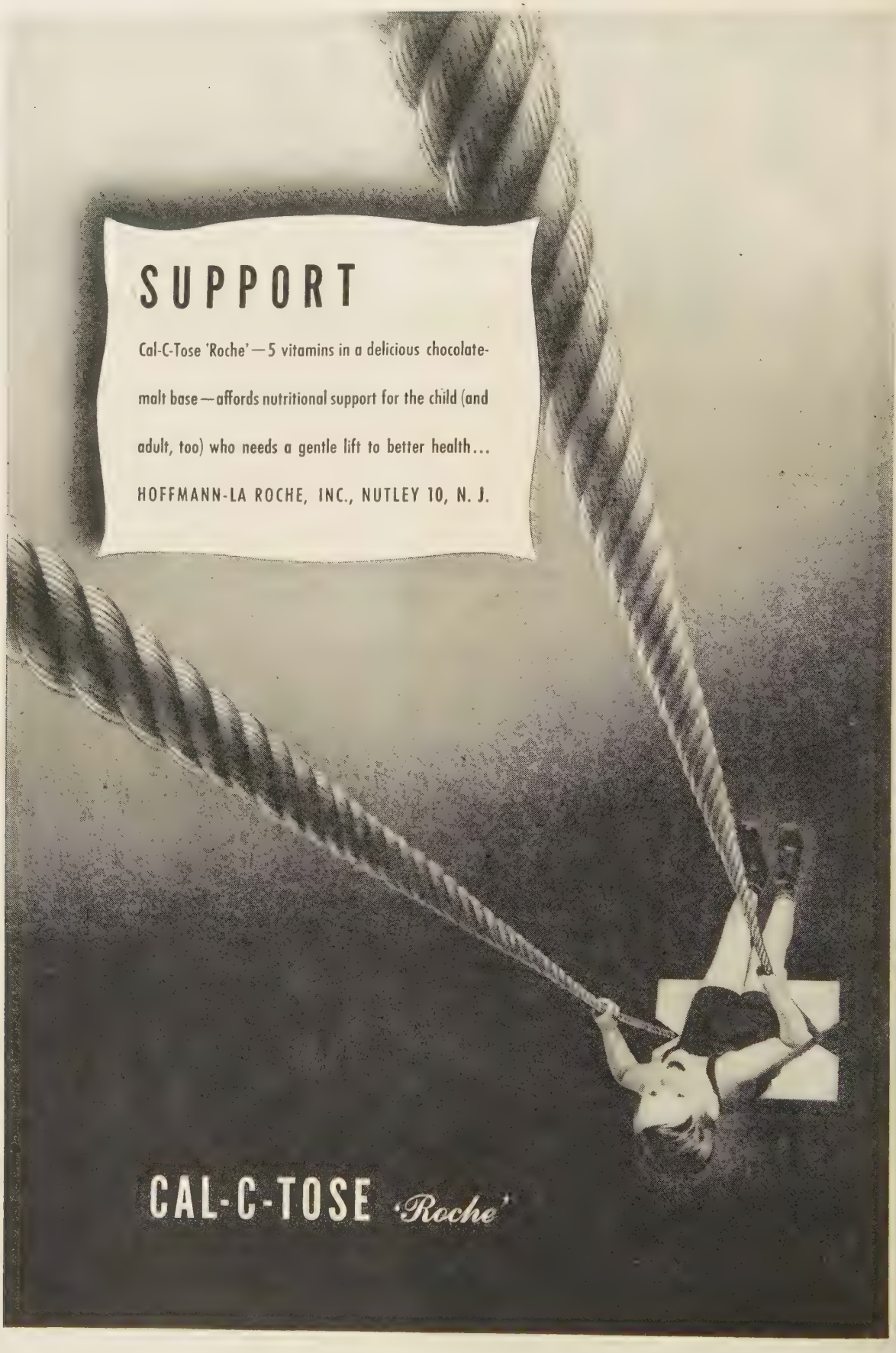
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EXTERNAL CEPHALIC VERSION IN THE TREATMENT OF BREECH PRESENTATIONS

GEORGE H. RYDER
New York, N. Y.

The maneuver of external cephalic version has long been known to obstetricians and has frequently been advocated by writers of text books on obstetrics, as a means of reducing the number of breech deliveries. By this maneuver the presentation is changed from breech to vertex before labor. It is well recognized that vertex births are far safer and less likely to result in babies stillborn or severely damaged. However, there seems to be a strange reluctance among obstetricians to use this maneuver as a routine procedure.

Fetal mortality in breech deliveries has always been high, ranging according to different observers, from around six percent to as high as thirty-five percent, the average in primiparae being about ten percent. This is far too high. In addition to this, many babies who survive breech births, suffer injuries that cripple them permanently.

In 1923 (1) I published a report of fifty-nine breech presentations treated by prophylactic cephalic versions in 890 consecutive deliveries of private patients. And in 1943 (2) I published a second report of 258 cases so treated in the consecutive deliveries of 1700 private patients. The present article is based on this second report.

In the care of these 1700 women, an attempt was made to diagnose breech presentations early and, where feasible, to convert them to vertex presentations before delivery.

Among the 1700 women, 1721 babies were born, thirty-two before the period of viability and 1689 after viability. Breech presentations of the nonviable are of no importance and attention is directed only to the 1689 born viable (Table I).

Among these 1689 babies, 258, or about one in six were found in breech presentation at some time during pregnancy. At time of birth, however, due chiefly to external versions and in lesser degree to spontaneous versions, only forty-five or one in thirty-seven remained as breech presentations (Table II).

No attempt at conversion was made on twenty-nine of the 258, because of twin pregnancies, incomplete observation, consultations, etc.; and fifteen changed spontaneously to vertex. Conversions were tried on the remaining 214 (Table III).

Complete success was attained in 92.5 percent (198) vertex at time of delivery. Complete or partial failure of these attempts at conversion, all presentations being resulted in 7.5 percent (sixteen), because in some the presentations could not be changed at all (ten), or having been changed, reverted and were breech at delivery (six) (Table IV).

Table I: All Babies of Series, Viable and Nonviable

Number of Babies		*Breech Presentations*
Nonviable at birth	32	14 or 43.7 percent
Viable at birth	1689	258 or 15.3 percent
Total	1721	272 or 15.8 percent

Table II: Babies Viable at Birth (1689)

At some time during pregnancy	258
	or 15.3 percent; about one in six.
At time of birth	45
	or 2.6 percent; about one in 37.
	(Due chiefly to external cephalic versions)

Table III: Viable Babies Originally in Breech Presentations (258)

Left as breech with no attempt at version	29
Spontaneous versions to vertex	15
Conversions tried on	214
	258

Table IV: Conversions to Vertex Tried on 214 Babies

Complete success, vertex at birth	198 or	92.5 percent
Partial failure, changed but reverted breech at birth	6 or	2.8 percent
Complete failure, could not be changed, breech at birth	or	4.7 percent
	214 or	100.0 percent

Among the partial failures, there were three multiparae and three primiparae. In the multiparae, all presentations were changed to vertex at least once, but reversions occurred too near labor for further attempts at version. So no real failure at version occurred. In the three primiparae, all presentations were changed to vertex once, but second attempts failed.

Among the ten complete failures, there was one multipara and nine primiparae. The cause of failure in the multipara was multiple fibroids, and in the nine primiparae failure was due to the fact that all attempts were made too late, in the eighth or ninth months of pregnancy. Contributing causes were: in six, extended legs of the fetuses; in the other three, adhesions under abdominal scars, a small amount of liquor amnii, and excessive obesity.

Of the twelve failures, complete and partial, among primiparae, the complication of extended legs of the fetuses was present in nine or seventy-five percent, while *all* failures were in the eighth or ninth months of pregnancy.

It is to be noted, therefore, that in primiparae, two factors seemed to make external version difficult, extended legs of fetuses and delay in making the attempt until late in pregnancy. When both of these factors are present, failure is likely to occur. In the whole series, there was no failure at conversion to vertex before the eighth month of pregnancy, whether in the presence of extended legs or not, while without this complication, there were several successful conversions in or after the eighth month.

In multiparae, with the exception of one failure due to multiple fibroids, there was no complete failure at conversion, whether the attempt was made late or early, in the presence of extended legs or not.

As a result, therefore, of the systematic use of cephalic version, in this series of 258 viable babies found in breech presentation, over three-fourths (198) were changed to vertex, and so remaining at birth; 5.8 percent (fifteen) changed spontaneously and 17.5 percent (forty-five) were left as breech (Table V).

The forty-five represented the sixteen failures at version, partial and complete, and the twenty-nine on whom no attempt at version was made.

Table V: Conversions to Vertex in 258 Viable Babies

Changed by external cephalic versions	197	
Changed by internal cephalic version	1	
Total changed artificially	198 or	76.7 percent
Changed spontaneously to vertex	15 or	5.8 percent
Changed artificially and spontaneously	213 or	82.5 percent
Remaining breech at birth	45 or	17.5 percent
	258 or	100.0 percent

External Versions With and Without Anesthesia

No anesthesia was used in changing presentations from breech to vertex by external versions in over ninety-five percent of the babies. In nine only, or in less than five percent, was anesthesia used, all nine being in the eighth or ninth month of pregnancy. So, all conversions performed before the eighth month of pregnancy were without anesthesia. Of those performed later, about a fifth required anesthesia (Table VI).

Table VI: Anesthesia in Conversions to Vertex by External Versions

Without anesthesia	194 or	95.6 percent
With anesthesia all in eighth or ninth month.	9 or	4.4 percent
	203 or	100.0 percent
Conversions in eighth and ninth months:		
With anesthesia	9 or	19.1 percent; about one-fifth
Without anesthesia	38 or	90.9 percent
	47	100.0

Months in Which External Versions Were Performed

About three-fourths of the versions were performed in the sixth and seventh calendar months, the rest in the fifth, eighth and ninth months.

Months in Which Spontaneous Versions Occurred

Spontaneous versions, breech to vertex, took place with fifteen babies, about equally divided among primiparae and multiparae. Two-thirds occurred in the sixth and seventh calendar months. Thus, Nature's time for spontaneous versions corresponded with the obstetrician's time for artificial versions, two-thirds of the former and three-fourths of the latter occurring in the sixth and seventh months.

The total number of external versions performed on 203 babies was 355, as in many cases, several versions were performed on one baby before the presentation remained vertex. On one baby there were nine versions and on another thirteen. All repeated versions except two were in multiparae (Table VII).

Table VII: Total Number of External Versions Performed (355)

In 154 multiparae	304 external versions
In 49 primiparae	51 external versions
Total 203	355 external versions

The total number of external versions attempted was 368, in multiparae 305 with one failure, and in primiparae sixty-three with twelve failures (Table VIII).

Table VIII: Total Number of External Versions Attempted (368)

In 155 multiparae,	305; successful,	304; failures,	1
In 58 primiparae,	63; successful,	51; failures,	12
Total 213	368	355	13

Reversions to breech after first external versions occurred in about one-third of the babies; in about ten percent in those of primiparae and in about forty percent in those of multiparae. Of five babies reverting in primiparae, two were returned to vertex and three could not be returned. Of sixty-five reverting in multiparae, all but three were returned to vertex by one or more external versions. These three were left as breech without further attempts at version (Table IX).

Table IX: Reversions to Breech After First External Versions

In 49 primiparae	5 or 10.2 percent; about 1 in 10
In 154 multiparae	65 or 40.2 percent; about 4 in 10
Total 213	70 or 34.5 percent; about 1 in 3

Cords Around Fetal Necks After External Versions

In this series, the incidence of cords around fetal necks was higher among babies on whom external versions had been performed than among those on whom no versions had been performed, though in the former the complication caused no fetal loss, while in the latter it caused a slight mortality. Although this absence of fetal loss in the former is probably a fortunate coincidence, it is worthy of mention (Table X).

Table X: Cords Around Necks in Babies With and Without Version

	Babies	*Cords Around Necks*	*Loss from Cords*
Versions on	203	64 or 31.5 percent one in three	0
No versions on	1518	351 or 23.1 percent one in four	6 or 1.7 percent
All in series	1721	415 or 24.1 percent one in four	6 or 1.4 percent

Incidence of Cords Around Fetal Necks Not Increased by Repeated Versions

The incidence of cords around fetal necks did not increase with the number of versions performed. On

each of 139 babies, one version only was performed. Among these, the incidence of this complication was 35.2 percent. On each of 64 babies, two or more versions were done, and among these the incidence was 23.4 percent. Thus, repeated versions on one baby did not seem to entail additional danger of this complication.

Cords Around Fetal Necks After Spontaneous Versions

After the fifteen spontaneous versions from breech to vertex, the incidence of cords around fetal necks was twenty percent. While the number of cases is too small for serious consideration, yet they serve as a reminder that cords may become wound around fetal necks after spontaneous versions as well as after artificial ones.

Delivery of the 258 Babies Originally in Breech Presentation

Of the babies originally in breech presentation, over three-fourths (204) were delivered vaginally as vertex; about thirteen percent (thirty-three) vaginally as breech; and eight percent (21) by section. A little less than half of the sections were performed because of the breech presentations, the others for reasons unconnected with the presentation. Of all the 258 babies originally in breech presentation, 3.5 percent were delivered by sections because of persisting breech presentations. All these were babies of primiparae (Table XI).

Table XI: Delivery of 258 Babies Originally in Breech Presentation

As vertex, vaginally	204	or 79.1 percent
As breech, vaginally	33	or 12.8 percent
By section:	21	or 8.1 percent
	258	100.0 percent

Converted—vertex 9
Not converted—breech 12
Because of breech, 10 or 3.5 percent all in primiparae.
Because of fibroids, 2.

Reasons Why Thirty-three Babies Were Delivered Vaginally as Breech

The thirty-three babies delivered vaginally as breech were those in twin pregnancies; those not under observation in the latter part of pregnancy; those changing spontaneously from vertex to breech too late for attempts at version; two in consultations after labor had started; and two upon whom artificial versions had failed.

Of the babies having breech deliveries, only six were of primiparae at term with single pregnancies. And of these six primiparae one was never seen until well advanced in labor and three were not seen during the last weeks of pregnancy until just before labor. Two only had breech deliveries because of failure of external versions.

It follows, therefore, that in the consecutive deliveries of 1700 women, of all under complete observation during pregnancy, only two primiparae at term with single pregnancies had breech deliveries.

Fetal Mortality

The fetal mortality from all causes among the 258 babies originally in breech presentation, was 8 or 3.1 percent. The corrected mortality or that from dystocia, was 2 or 0.8 percent.

Six of the babies were lost from causes unconnected with delivery, placenta previa, accidental hemorrhage. Of the two babies lost from dystocia, the mother of one was first seen in consultation after more than forty-eight hours of a dry labor with impacted breech, and the mother of the other was not under observation during the better part of the last month of pregnancy, due to a sinus infection. External version was not tried on either of these two from lack of opportunity.

Therefore of all the babies whose mothers were under observation before pregnancy, the loss from dystocia was 1 or 0.4 percent (Table XII).

Table XII: Fetal Mortality of 258 Originally in Breech Presentation

From all causes..... 8 or 3.10 percent.
From dystocia.....2 or 0.8 percent; omitting one consultation .....1 or 0.4 percent.

Moreover, among all the babies on whom cephalic versions were tried, successfully or unsuccessfully, not only was there no loss from dystocia, but there was no injury. The only loss from dystocia was one (excluding the consultation) on whom version was not attempted from lack of opportunity.

Maternal Mortality

There was no mortality or injury among any of the women upon whose babies versions were performed or attempted.

Comments

In this series of breech presentations treated by prophylactic cephalic versions, of all conversions attempted 92.5 percent were entirely successful. Over three-fourths of the babies were changed by external versions to vertex and were so delivered. Sections were performed on 3.5 percent for persisting breech presentations. Only six term babies of primiparae in single pregnancies were delivered vaginally as breech. There was no loss from dystocia among any of the babies on whom versions were performed or attempted and no baby or mother sustained injury. And the total fetal mortality from dystocia among all of the 258 babies found in breech presentation, was 0.4 percent (excluding one consultation).

No comparable series of breech presentations showing such a low fetal mortality from dystocia has been reported, to my knowledge, but I believe others can obtain equally good results by the systematic use of prophylactic external versions. Without prophylactic versions, I doubt that it is possible unless the incidence of sections performed is unduly high.

Why is there this reluctance of so many obstetricians to adopt external versions as a routine procedure in the management of breech presentations? From talks and correspondence with quite a number, I find there are several reasons.

Some say that they have had no success with the maneuver. This is probably due to the fact that sufficient care is not given to early diagnosis and breech presentations are not discovered until late in pregnancy when external version is difficult. It is usually easy before the eighth month of pregnancy and progressively more difficult as the term approaches. Systematic attempts at versions in the sixth and seventh months of pregnancy would bring success. In many series, there was no failure in these months.

Again, it is argued that most breech presentations change spontaneously to vertex and so why bother with unnecessary artificial ones. It is true that most do

change spontaneously but all do not, and no one can tell which babies will be left in breech presentation to face the danger of breech delivery. For those so left the choice must be made, in primiparae, of subjecting the babies to the well known hazard of breech delivery or the mothers to the equally well known risk of section.

Others say that they believe in external versions but only in the eighth month of pregnancy, because most spontaneous versions occur before that time. This is true, but those so arguing frequently fail to perform versions which earlier could have been accomplished easily.

Some obstetricians say external versions are unnecessary because they are proud of their skill in conducting breech deliveries and claim that barring complications such as deformed pelves or disproportionately large babies, they can get as good results in breech deliveries as in those vertex. Statistics will not support this claim. In any large series, conducted by the most skillful, fetal loss and injury are always found higher in breech deliveries than in vertex deliveries.

External versions are avoided by some men because of fear that they may cause winding of cords around fetal necks. It is true that they may, but so may spontaneous versions. And there is no reason for thinking that one carries greater danger of this complication than the other. So, for fear of cord complication, it is illogical to refrain from artificial versions and to rely on spontaneous ones.

Others say that external versions are not worth doing because reversions occur so frequently. Reversions are rare in primiparae but very frequent in multiparae where external versions are easy. So reversions need cause no discouragement, for provided too long a time is not allowed to elapse between attempts, the versions may be repeated as many times as necessary, without danger and without increasing the incidence of cord complications, as shown in this series.

Still others fear that external versions may cause premature labors. Judging from this series, the fear is groundless, for in the whole series of 1700 deliveries, the incidence of premature labors was less among the babies on whom versions had been performed than among all the viable babies on whom no versions had been performed. External version actually lessens the danger of premature labor, for the percentage of premature labors is greater in breech presentations unchanged than in vertex presentations.

Finally, there are some men who say that they will not try external versions because they are dangerous. If carefully performed, they cannot be very dangerous, for in this series 355 first and repeated versions were performed without injury to any baby or mother.

None of the foregoing arguments against external version carry much weight. And outweighing all arguments against it, is the undeniable fact that vertex deliveries are safer than breech deliveries, and that external version will reduce fetal mortality by substituting the former for the latter.

Space will not be taken here to describe in detail the method of performing external version. Suffice it to say that it is usually easy if performed early, when anesthesia is not necessary. It is generally better to work on the breech first, lifting it away from the pelvic brim and gently pushing it upward in the direction of the fetal back. When the breech arrives at or near the horizontal, slight downward pressure on the head will usually complete the version. The fetus should be turned in flexion, not in extension. It is well to listen to the fetal heart sounds before and after version.

After a successful version, the patient should be seen again in a week. For if reversion occurs, another version will be increasingly difficult as time elapses.

If failure attends the first attempt at version, the attempt should not at once be abandoned. For after a few days, a second attempt often proves successful. On occasion, with an x ray film for guidance, an attempt may be made under anesthesia, for version under anesthesia is preferable to a difficult breech delivery or a section. In my series 4.4 percent of the versions were performed under anesthesia after attempts without anesthesia had failed.

Conclusions

Breech deliveries have a high fetal mortality. So every fetus in breech presentation is in potential danger. This danger can be removed by external version.

Success in external versions depends upon early diagnosis of presentation by careful antepartum palpation. When diagnosis is in doubt, it can usually be made by vaginal examination and always by x ray.

External version should be performed gently and without haste. The use of force is dangerous. Carefully performed, the maneuver is not dangerous to fetus or mother.

The most frequent cause of failure is delay in making the attempt until late in pregnancy. The next most frequent cause is extended legs of the fetus.

The best time for performing external version is in the sixth and seventh calendar months. After this time spontaneous versions are less likely to occur and artificial versions are more likely to require anesthesia and to be failures.

Greater effort should be made to diagnose breech presentations early. An obstetrician who allows a pregnant woman in his care to go to term with a breech presentation undiagnosed, lays himself open to just criticism.

External cephalic versions, systematically employed, can reduce the fetal mortality following breech presentations to the much lower fetal mortality following vertex presentations.

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47 EAST SIXTY-THIRD STREET

Penicillin Study Instituted at Fort Bragg

The new method of administering penicillin which has been developed by Captain Romansky, of the Army Medical Corps, prolongs the action of the drug by suspending it in a mixture of four percent beeswax and peanut oil. Captain William Leifer, of the Medical Corps, is instituting a study of the new method at Fort Bragg Regional Hospital. Dr. Charles Rammelkamp, a member of the Commission on Acute Respiratory Diseases, Epidemiological Board, Preventive Medicine Service, Office of the Surgeon General, will act in a consulting capacity with Captain Leifer. It is believed the new method will have important effects upon the uses of this medicinal agent.

THE CHEMICAL NATURE OF ALLERGY

CLIFFORD L. BARTLETT
Pasadena, Calif.

In their paper "The Chemical Control of Allergy", published in 1940 in London, Evans, Bodman and Maisin (1) submitted the suggestion that "For reasons which will be explained, it appeared to us that a departure from normal in the chemistry of cellular metabolism, involving the absence of certain catalysts of coenzyme activity, is the primary cause of allergic manifestations." They summed up the basis of their theory as follows:

1. "The chemical energy produced and distributed by the metabolic activity of the living cell is essential for its normal function. Abnormalities of such metabolism involving an alteration in oxidation reduction reactions within the cells are, we believe, responsible for the production of the allergic state. Such changes may be due to the effect of shock, whether infective, traumatic or emotional, generally occurring in a person rendered susceptible by inherited tendency. The site and specific nature of the cells affected would alone determine the type of allergy exhibited.

2. "If this is so, the fundamental need in the treatment of the allergic state will be the recovery of the normal oxidation chain involved in the production and normal distribution of cell energy. This appears to depend on the restitution of a normal carrier catalyst cycle by the provision of a substance (an oxidation catalyst) the absence of which is the direct result of the kind of trauma already referred to."

The biochemical considerations underlying their idea were briefly summarized in their paper, and as a preliminary to a consideration of the chemical control of allergy, it will be of interest to examine in as simple and brief a manner as the subject permits that aspect of the cellular chemistry which is primarily involved in their thesis.

Metabolism

Before it is possible to appreciate the significance of a departure from normal in cellular metabolism, it will be useful if we first remind ourselves of some of the major processes of normal metabolism. For this purpose, it will be most simple to summarize the normal processes of the metabolism of carbohydrate. The summary will be deliberately freed from detail concerning the various side reactions which accompany the major breakdowns, in order to leave the issue as clear as possible.

Carbohydrate is broken down and liberates energy in two ways: 1, by the breaking of carbon chains; 2, by what seems to be the ultimate aim of cell metabolism, the union of hydrogen with oxygen to form water.

The whole process of obtaining energy for the requirement of the body might be summed up as the splitting of water into its component parts and their eventual reassembling. For example, the chlorophyll of plants captures the energy from the rays of the sun and uses it to separate H and O, fixing H to the carbon of CH_2 and sending the oxygen back into the air again. This H fixed to C in the form of carbohydrate is the immediate source of energy of plant and animal. In cellular oxidation, the cell takes the H from the C and eventually lets it unite with oxygen to form water again, using the energy of the reaction for its own purposes. This process has been pictured by Szent-Gyorgi (2) in the following equation:

$$\text{Energy} + n\text{CO}_2 + n\text{H}_2\text{O} = n\text{O}_2 + \text{C}n\text{H}_2n\,\text{O}n$$

The breakdown of the food molecule then being represented as follows:

$$\text{C}n\text{H}_2n\,\text{O}n + n\text{O}_2 = n\text{H}_2\text{O} + n\text{CO}_2 + \text{energy}$$

In other words, the energy liberated by the oxidation of the hydrogen in the food molecule is the sole source of body energy. Since the immediate oxidation of the hydrogen would result in the too rapid release of energy, the processes of biological oxidation provide for the gradual release of the energy of the H through a series of carefully graduated stages. This stepping down is affected by a series of enzymes.

Chemical Breakdown of Metabolities Energy Production in the Cell

One is accustomed to think of the process of oxidation as being accomplished primarily by oxygen. In cellular chemistry it is now known that through the activity of what are known as "oxidation-reduction" processes, the more important factor is the transfer of hydrogen atoms. The various stages in the breakdown of carbohydrate by the breaking of carbon chains are accomplished through the action of a series of enzymes, known as dehydrogenases, whose function it is, in the presence of a suitable acceptor, to split off hydrogen atoms. To repeat and put it the other way around, a dehydrogenase is an enzyme which has the faculty of promoting oxidation by means of the removal of hydrogen. It will suffice to show one typical example of this action, namely, the change from lactic acid to pyruvic acid, which simply involves the loss of two atoms of hydrogen by the lactic acid, as follows:

$$\underset{\text{lactic acid}}{\text{CH}_3.\text{CHOH.COOH}} = \underset{\text{pyruvic acid}}{\text{CH}_3.\text{CO.COOH}} + 2\text{H}$$

It must be borne in mind that in most of the steps involved in carbohydrate breakdown, a series of these dehydrogenases, or hydrogen carriers, is required. Absence of any one of them obviously would be enough to upset the whole series of reactions. The 2H is passed by this series of dehydrogenases, or hydrogen acceptors, from one to the other, until the point is reached where the activated O is met. Each stage of hydrogen acceptance and transmission involves the presence of a suitable activator and transmitter.

In the case of the oxygen, there is a series of substances consisting of protein molecules containing a trace of metal. These act as oxygen carriers, or, more accurately, as electron carriers. The O_2 activates the metal, removing an electron. The hydrogen donates an electron to the metal, thus becoming positively charged, i.e., an H ion. The H ion can then unite with the O_2 to form water.

The socalled process of oxidation, therefore, involves a chain of hydrogen carriers and a chain of oxy-

gen or electron carriers, in which the O_2 does not take any part until the end of the process, where it unites with the H to form water.

It will thus be seen that the functions of the dehydrogenases, the hydrogen acceptors and the oxygen activators are vital to the whole process of biological oxidation and hence to life, since all our vital energy is derived from the gradual approach of the H to the O and the eventual union with O. Thus any breakdown at any stage of the process would not only interfere with the normal production of energy, but in all probability would result in an abnormal chemistry, which might have far-reaching results.

One can now summarize, very briefly, the principal steps in the chain of carbohydrate metabolism, so that the importance of the steps in which we are primarily interested can be observed.

Some Phases of Carbohydrate Metabolism

Polysaccharides are phosphorylyzed to monosaccharide, or hexose phosphates.

Monosaccharides (phosphorylated six carbon chain sugars) form hexose diphosphate.

Hexose diphosphate splits to two triose (three carbon chain) phosphates.

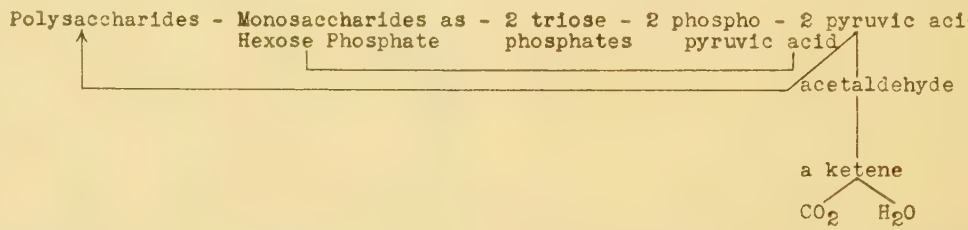
These three carbon chain phosphates are broken down to phosphopyruvic acid, which then loses its phosphate, leaving pyruvic acid.

Pyruvic acid is then broken down to acetaldehyde.

Acetaldehyde possibly leads to the momentary formation of a ketene. ($Ch_2.CO$).

The ketene, being the final breakdown product of a carbohydrate, oxygen would enter the molecule, leading to the formation of carbon dioxide and water.

This may be expressed graphically as follows:


Polysaccharides - Monosaccharides as Hexose Phosphate - 2 triose phosphates - 2 phospho pyruvic acid
acetaldehyde
a ketene
CO2 H2O

Departure From Normal Chemistry

At this stage it will be useful to examine more in detail the chemistry of two of the more important steps in the series of changes to which reference has been made, because they will illustrate clearly how the type of difficulty which is under discussion can and does arise.

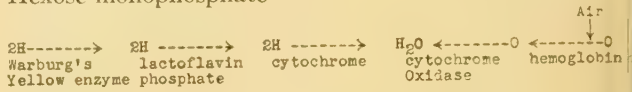
First, the step from pyruvic acid to acetaldehyde. Pyruvic acid is broken down to acetaldehyde with the aid of an enzyme, which is a carboxylase and a co-enzyme, which is a pyrophosphate ester of Vitamin B_1 (3) thus:

$CH_3.CO.COOH \ldots CH_3.CHO \quad CO_2$
(pyruvic acid) (acetaldehyde) (carbon dioxide)

When this reaction is not complete, pyruvates accumulate, causing the polyneuritis for which Vitamin B_1 is now so commonly known to be effective. This is one example of the fact that the unsaturated products of both sugar and fat metabolism, as well as of other normal cell constituents, may be diverted from their normal service so as to cause disease.

Another step of special interest is the breakdown of hexose monophosphate which loses by dehydrogenase action two atoms of hydrogen. These will eventually combine with oxygen to form water, but they have to be "carried" toward the oxygen by the substances known as "hydrogen acceptors". In this instance, the first acceptor is Warburg's yellow enzyme. This passes the hydrogen to lactoflavin phosphate (B_2). Thence, it is passed to cytochrome. It is now ready to be passed on to oxygen, but the oxygen in its turn also needs carriers. Hemoglobin accepts oxygen from the air and passes it to cytochrome oxidase. Then the two atoms of hydrogen from the cytochrome and the atom of oxygen from the cytochrome oxidase meet and water is formed. The operation may be pictured thus:

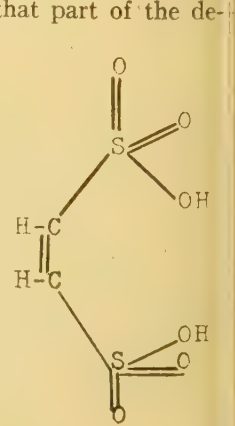
Hexose monophosphate



This complex reaction can be inhibited, or even paralyzed, by certain pathological changes, as well as by such narcotics as morphia, anesthetics, barbiturates, alcohol; by the sulfa group and possibly even aspirin and tobacco. The toxins of certain intestinal anaerobes and many bacterial toxins, have been shown by Wooldridge and Higginbotham (4) to inhibit dehydrogenase reactions.

Since it has been demonstrated (by Goldie and Sandor 5) that ketene of the type which is referred to can destroy the anaphylactic power of antidiphtheritic serum without affecting its antitoxic power, by blocking the amino groups, it is suggested that the normal means of defense of the body against allergic attack is by the continual formation of such a substance as a ketene by tissue cells in their normal metabolic processes, and its absence, due to inherited faulty metabolism, or inhibition by bacterial toxins, in an individual whose metabolism was already imperfect, would result in the appearance of allergic symptoms.

Treatment would therefore be designed to re-establish the normal channels of breakdown via a ketene and this might be accomplished by the use of such an oxygen carrier catalyst as might replace that part of the dehydrogenase coenzyme system which is postulated as being absent.



It was anticipated in the theory advanced by Evans and his coworkers that the missing catalyst would be a short carbon chain compound having two or more unsaturated carbon linkages. Consequently, a number of such bodies were produced, the most satisfactory of which is the one based on ethylene disulphonic acid, the hypothetical formula of which would be $C_2H_2(SO_3H_2)$.

Ethylene disulphonate was then prepared, in a dilution of 1:10-15, to correspond approximately with the dilution in which such substances generally are found in health. It is not inferred, at the moment, that ethylene disulphonate is indeed the oxidation catalyst actually present in normal health. Further experimental work will be necessary before that point can be decided. In view of the chemical reactions to which reference has been made, ethylene disulphonate is a substance having an atomic structure analogous to that which one would expect the oxidation catalyst involved in the cellular chemistry at the particular point discussed to have. All that can be said at the moment is that when introduced into the body chemistry of an allergic person, it appears to behave in the manner which would be anticipated were it indeed the catalyst actually present in normal health. This will be more clear when one comes to a discussion of the clinical findings.

When considering the tenability of this theory, it must be borne in mind that, as already stated, the normal process of the metabolism of carbohydrate outlined has been freed from detail concerning the other side relations which occur. For example, the breakdown of pyruvic acid to acetaldehyde is discussed, but there are, as Peters and Lemberg have shown, ten or more ways in which pyruvic acid is broken down, so that the breakdown to acetaldehyde is only one of several possible courses. Moreover, definite proof of the formation of a ketene from acetaldehyde remains to be provided. Further, the experiments by Goldie and Sandor to which reference is made were performed with ketene in quite high concentrations. The theory advanced is offered as a theory only, in the belief that it is, at least, a good foundation upon which to pursue further research and study.

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65 North Madison Avenue

DENGUE FEVER IN AUSTRALIA

A Brief Review of One Thousand Cases Treated

BERNARD M. ZUSSMAN
New York, N.Y.

Dengue, or breakbone fever is very common in the northern or rainy belt of Australia extending from Townsville on the east to Port Darwin on the northwest. While attached to the Twelfth Station Hospital, I had occasion to study these cases.

The disease is ushered in by an acute onset of fever, chills and severe backache. However, the fever usually does not rise above 103°, whereas in malaria, the fever frequently reaches 105° or 106°. There is no definite cycle of intermittent fever and chills in dengue, as several chills may follow each other in rapid succession. The chills might be as severe in dengue as in malaria. Backache is an invariable part of the disease, being severe, situated over the lumbosacral region and causing great pain and distress. There are also muscular aches and pains in the legs, thighs and arms. One of the most characteristic features of the disease is severe retrobulbar pain on moving the eyeballs.

The disease is self-limiting, in one week to ten days, but has a marked tendency to relapse. In about one-half the cases there is a maculopapular rash having the same face and body distribution as the rash in measles. In a number of cases there were also bilateral conjunctivitis as well as Koplik spots. However, there were no respiratory complications such as bronchitis or pneumonia.

As in malaria, dengue fever requires the mosquito for an intermediate host, and the same preventive measures apply to both conditions. A study of the blood showed a fairly normal white and differential count though there was a tendency to leucopenia. There was no eosinophilia. The sedimentation rates were not elevated above the normal values of 4-6, whereas in malaria there was almost invariably a high sedimentation rate of 20-40, which persisted for months after the cessation of clinical symptoms.

The treatment was symptomatic; rest in bed, the forcing of fluids, and the administration of one of the coal tar preparations. APC capsules, one every four hours, were found valuable, as was also sodium amytal, three grains. Alcohol rubs and back massage were found extremely effective in allaying the severe backache and muscular pains. Patients were kept under mosquito netting until their temperatures were normal for several days. They were then allowed to walk to the regular patients' mess.

As malaria fever is the next most prevalent fever in this region, I present herewith in tabular form, the principal symptoms of dengue and malaria, which will aid in making a differential diagnosis.

Differential Table of Symptoms

Symptoms	*Dengue*	*Malaria*
Vomiting	Slight or none	Marked
Fever	103 or less	Frequently up to 105°
Chills	Not intermittent	Intermittent
Retrobulbar pain	Present	Not present
Leucopenia	Present	Present
Sedimentation	Normal	Elevated
Rash	Maculopapular in about fifty percent	No rash
Etiology	Aedes ægypti	Anopheles

Reference

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393 West End Avenue

The Cutler method for sedimentation rate was used.

Symposium on Endocrinology

ACROMEGALY

Case Report and a Physiognomic-Endocrinological Study

HANS COHN and IRMA COHN
Cleveland, Ohio

In the first decades of the nineteenth century, many physicians following in the footsteps of Lavater, applied the theory that an individual's physiognomy is significant of his moral character and that even the diagnosis of diseases may be so made.

Nevertheless, the definition of a facies luetica or phthisica was not convincing and this diagnostic method was forgotten. The striking physiognomy of the acromegalic patient was not overlooked. However the connection between the altered appearance of the pituitary gland and the accompanying pathology of this bizarre physiognomy was only first described in 1896 by Pierre Marie.

One may be tempted to repeat this physiognomic form of diagnosis if it is based upon a more intimate knowledge of the inner secretory glands. The hormonal secretions of these glands produce striking effects on the face of a patient with Graves' disease, or with myxedema, and most certainly dramatically influence the face of an acromegalic patient.

The condition of acromegaly is seldom encountered hence only approximately one thousand six hundred and sixty-one cases appeared in the literature up to the year 1942, although undoubtedly quite a number of cases were not published.

One unpublished case concerned a fifty year old woman almost completely blind who had acromegaly and was operated upon in 1913 by the transsinusal method. Death followed operation within eight hours.

The protean character of the disturbances in acromegaly and its rarity may justify the publication of the following case observed during our practice in Cleveland.

In August 1943, a fifty-eight year old white patient presented himself complaining of terrible headaches, and severe fatigue. He was not able to leave his home because his "knees gave way" and he was not able to stand nor to walk. Appetite was very poor. Belching and nausea occurred even after the slightest food intake. In addition, he had severe headaches, pain in his knees and was troubled with constipation. Because he had some chills, he thought he had a cold, "particularly because of a clogged nose".

He stated that he had been treated for anemia six months previously and had received liver therapy. During one month of this period he had to forego his usual work as superintendent of an apartment house where he did all the repair work. His childhood was spent in an orphans home. When fifteen years old, he commenced work as a carpenter. From his nineteenth to his twenty-third year he served in the Ohio National Guard. In 1931 while performing hard laborious work he broke two ribs and was hospitalized for four weeks. Upon complaint that the ribs bulged out on his right chest and that he could hear "the noise of their cracking" an operation was performed one month later (bloody reposition because of non-union).

When questioned because of the enormous size of his hands and feet, he related that he had had big hands since childhood and that he was nicknamed "the fellow with the big hands" by his coworkers. It was increasingly difficult for him to obtain the right size of shoes because of his conspicuously large feet. During his service in the National Guard he experienced no difficulties in wearing the normal-size uniform, cap, shoes, etc. In later years he encountered increasing difficulties getting a proper fitting coat because his "chest became always wider". His maximum weight at any one time had been two hundred pounds. He never craved for sweets or for starchy foods; was always a moderate eater and drinker. He had many blood tests which were always negative for syphilis and denied having had any venereal infection. He has been married for twenty-five years and although sexually normal, the marriage has been childless. For the past five years he claims that he has been impotent.

When married in 1915 his weight was one hundred and eighty-one pounds. At that time he wore shoes of normal size, whereas he now wears shoes size thirteen and one-half. He stated that he could not purchase proper-fitting gloves because of the size of his hands. Now, his height is five feet eight and one-half inches, in contrast to the Army measurement of five feet ten inches (that was forty years ago).

Besides his operation for rib fracture, he had a tonsillectomy about fifteen years ago. Both operations were made under ether narcosis. His headaches apparently began nine or ten years ago. His urine was examined frequently and was supposed to be always normal. The patient's taste and smell have always been good; he does not perspire.

The patient is of tall stature, with a pale face and very light colored skin. He has full, white, blond hair, which he wears neatly combed. His posture which is bent forward and his large hands and big feet, together with the typical acromegalic face, the big forehead, big nose and protruding jaw, give him a kind of orangutan-like appearance—more aptly described as a "reversion to the gorilla type". He has been edentulous for ten years and wears a prosthesis, which enables him to chew his food without difficulty. Before he had "spaces between his natural teeth". The chest shows the scars of an operation for the broken ribs on the right lower side. One is impressed by the bulging of the sternal part and the balcony-like protruding processus xiphoides sterni. He shows no alteration of hirsuties and the other sec-

ondary sex characteristics are normal. The testes in the scrotum are of normal size and the penis is likewise normal. Lungs are in normal limits on percussion. The heart dullness shows no enlargement, particularly the dullness by percussion of the sternum is not enlarged. Heart sounds are low but normal. The manubrium sterni is diffusely thickened, a sign of hyperostosis of this bone which often simulates the thymus dullness.

There are no signs of visceral enlargement in the abdomen. The liver dullness does not transgress the right costal arch, nor is the lower liver margin palpable below that line. The spleen is not palpable, its dullness is within normal limits.

His head is characteristically distorted with the enlarged facial portions before a normal cranium and projected bushy eyebrows with a large forehead, which projects over deep sunken enlarged eyeballs. The lower jaw is enormously enlarged (prognathism). The middle part of the mandibular bone is prolonged and the angle between both widened. The hands are spade-like and characteristically enlarged. There is a characteristic kyphosis caused by the growing vertebræ and inharmonious development of the anterior ligaments.

The lower lip is somewhat ectropionized resembling the characteristic "lip of the House of Hapsburg". This hypertrophy of the lower lip occurs routinely when there is lack of pressure from opposing tissue, as in harelip (1).

There is a marked sagging of the lower lid of each eye and the skin is extremely loose around the orbital region. The nose is protruded though breathing through the wide nostrils is unimpaired. The feet are enormous. The gait is sluggish; the patient resorting frequently to a cane because of weakness "in his knees".

The nervous system is unimpaired. Pupils react to light. Patellar reflexes are both obtainable. There is slight Romberg. No zones of paresthesias or signs of disturbed sensations, no signs of locomotor ataxia, knee-nose test, heel-knee test is sluggish, but not atactic, Achilles reflex is hard to obtain but positive on both sides.

Ophthalmological Findings

An eye specialist sent the following report concerning the ophthalmological findings.

The conjunctivæ are very pale; lacrimal apparatus, sclera-cornea and anterior chamber are normal. There is slight heterochromia of each iris. Pupil reaction to light and the finger tension are normal.

Internal examination.—O.D.: "Media clear, disc is oval with long axis in the vertical, fairly good color with deep cap on the bottom of which can be seen some very tiny capillaries. The nasal margin of the disc is a little fuzzy. Vessel ratio is four to two. . . Macula and periphery are normal.

O.S.: The disc is irregularly round and the findings are about the same as in the right eye. Vision in the right eye is 20/50. Vision in the left eye is 20/200.

Vision field.—The field is contracted on the temporal side in the left eye for a maximum of forty degrees. In the right eye it is constricted less temporally . . . The blind spots are not enlarged. In evaluation these cuts in the visual fields one must remember that the patient has very heavy brows, that the eyes are deep set and perhaps ten or fifteen degrees of his cut is due to these mechanical factors. It may be that one could say that the patient has an early bitemporal hemianopsia, which is characteristic of pituitary gland enlargement."

The patient can still see and read without glasses very well but says that after reading for a certain time the lines become somewhat blurred.

Laboratory report.—Blood sugar (fasting state), 120 mgrs.; blood nonprotein nitrogen, 30 mgrs.; blood calcium, 7.4 mgrs.; blood urea, 16 mgrs.; blood phosphorus, 5.6 mgrs.; blood creatin, 1.5 mgr.; blood cholesterol, 188 mgrs.; blood count: red blood cells, three and one-half million; white blood cells, about six thousand.

Sedimentation rate is normal. Urine repeatedly tested shows no saccharum, but an albuminuria of two per mille. There is no polyuria, the specific gravity is 1025. The urine is sour, of light color but has a very sharp odor. Sediment: very few granulated cylinder (casts), few red blood cells and epithelia.

Blood pressure is routinely measured 115/60, pulse rate 80 per min.

X ray report.—The x ray picture of the typical acromegalic skull shows the destruction of the sella turcica, the thinning of the processus clinoidei, anterior and posterior, the deformity of the dorsum as well as the extreme enlargement of the sinuses. It can be judged best by comparison with a normal sella turcica in a normal skull.

The x ray picture of the hands shows the enlarged distal phalanges, the moderate tuffing of the end phalanges, and some bony defects on both thumb end phalanges. (Compare these particular osseous defects with the hand in Case 4 of Goldberg and Lisser, 2.)

Our patient sustained two broken ribs, a plight similar to that of the patient in Case 2 of Goldberg and Lisser (2). Our patient, as in Goldberg and Lisser's case (2), had a permanent deformity of his chest. In our patient there was a non-union of the rib fragments which needed operation. This traumatic lesion may be purely an accidental coincidence, but it may suggest also that there is a higher degree of bone porosity in spite of stronger ossification in others in the acromegalics. It may be due to a disturbed blood calcium regimen of the parathyroids or by altered growth hormonal activity of the pituitary gonadotropic hormone. The lack of pigmentation of the skin is apparent (albinotic). The skin and subcutaneous tissues are not thickened except on the nose and nasolabial folds.

The anthropometric measurements of the patient (adaptation of Goldberg's and Lisser's (2) measurement chart) are presented in the accompanying table.

These measurements are similar except for the weight increase. Blood pressure, last, 115/80; pulse 80.

The diagnosis of acromegaly was obvious, however the therapy to be applied was debatable.

Surgical intervention did not seem indicated in view of the age of the patient, the long duration of his endocrine disease (about forty years) and because the patient's vision was not severely disturbed or endangered.

Therapy of choice appeared to be x ray treatment for the relief of headaches and the extreme weakness. Although x ray therapy is generally accepted, it is by no means elective in its effect on those parts of the gland affected by the disease (2).

Adelstein (3) observed the effects of roentgen rays on the human pituitary or at least on an eosinophilic adenoma of the gland. He asserted "the histological changes

attributable to roentgen ray therapy were minimal and not indicative of therapeutic effectiveness".

Neither form of treatment, the surgical nor the x ray, seemed to apply in this pituitary hormonal disturbance.

Anthropometric Measurements of Patient

	August 1943	April 1944
Age	58	59
Weight	181 pounds	183 pounds
Height (standing)		171.25 cm
(sitting)		133.75 cm
Chest circumference		100 cm
breadth (transverse)		31.5 cm
(depth)		31.5 cm
Shoulder biacromial		34 cm
Pelvis bicristal		30.5 cm
Head length		31.75 cm
breadth		15.5 cm
ear heights		15.2 cm
face length		19 cm
face breadth		14.1 cm
nose length		7 cm
nose breadth		5.5 cm
Hand length		20.5 cm
breadth		11.5 cm
Feet (left) length		11.5 in.
breadth		4.5 in.
(right) length		11¾ in.
breadth		4½ in.

The urge for a more radical attitude as promoted by Goldberg and Lisser (2) for the acromegalic operation because "the radical reduction or excision of the hyperfunctioning tissue constitutes the most logical and the most direct approach" does not seem fully conclusive in the light of the ever-increasing knowledge of the endocrine functions and the interrelationship of the endocrine glands.

In our case, the very low blood pressure, the extremely light colored skin, the great muscular weakness and the lack of pigmentation suggested, beside a disturbance of the growth factor, that there was a diminished secretion of the adrenotropic hormone of the pituitary. In the postmortem of the acromegalic patient in Goldberg and Lisser's case (2) are reported interesting fibrotic changes in the center of the adrenal gland "representing atrophy following hyperplasia".

The growth effects are irreparable, while the visual disturbances are light compared with the long duration of the illness in our patient, therefore an approach by the adrenotropic factor seemed logical. The patient, therefore, received ephedrine sulfate, three-eighth grain daily, and strychnine, one-thirtieth grain daily for four weeks.

Influenced by the reports of remarkable successes in the treatment of Addison's disease with desoxycorticosterone acetate 4, we decided to evaluate its efficacy in this particular case.

After four weeks of the foregoing, we administered five mg. of doca[1] (one cc of the oil solution) intramuscularly every week for nineteen weeks. This amount is recommended for the treatment of chronic deficiencies and asthenia and represents the equivalent of ten to fifteen cc of a highly active cortical extract. The fir four weeks of treatment did not bring any relief fr the complaints of the patient.

The patient has received since September, i.e., af five weeks, one cc of doca, in addition to ephedrine a strychnine in the above mentioned doses. From th time on he did not receive any other medication. Gra ually the patient's appearance became better, his p ture improved and his gait gradually lost its sluggis ness. He declared that his terrific temporal headach had disappeared completely. His bluish lips becam more pink colored and appetite and sleep were undi turbed. The patient who was previously apathetic a easily fatigued now became increasingly talkative a vigorous. He appeared regularly for his injections a climbed the office stairs without effort. He had no co plaints except for some pain in his back and was operative in every respect.

The urine is now odorless, sour, shows no saccharu and even the albumen content disappeared complete except for light opalescence. Appetite and thirst a normal.

From experience gained in treating this patient w believe that in cases of acromegaly with appare adrenocortical hormone deficiency substitution thera with desoxycorticosterone acetate is indicated.

[1]Synthetic desoxycorticosterone acetate, Roche-Organon, Inc., Nutley, New Jersey.

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9912 Lorain Avenue

The Thyroid Gland and Hemopoiesis

T. E. Wilson, of the Australian Army Medical Corp reviews the rôle of the thyroid gland in hemopoies (*Med. Jour. Australia*, March 25, 1944). Because of th somewhat conflicting reports of the results obtained b various workers, a study was made of the blood an bone marrow of a series of thirty-one patients sufferin from thyrotoxicosis and of one patient suffering fro myxedema. As far as could be ascertained, these pa tients were free from any other disease. In this stud no differentiation was made between hyperplasia of t thyroid and toxic adenoma of the thyroid. Sixte healthy young adults, who had been admitted to t hospital for treatment of hernia, hydrocele, or var coceles, were usd as controls. As a result of this exper mental work, which the author describes in detail, h concludes that the thyroid gland exercises a nonspecif control of the metabolism of all the marrow cells, re sulting in their hyperplasia in thyrotoxicosis and i their hypoplasia in cretinism and myxedema.

SEXUAL IMPOTENCE

A Plea for More Descriptive Terminology

EDWIN W. HIRSCH
Chicago, Ill.

Sexual impotence is, for the most part, poorly managed because of improper efforts at diagnosis. Males who complain of waning sexual power are, all too often, regarded as instances of hormonal deficiency. Sexual capacity or sexual desire is not regenerated by injections of testicular hormone unless the testicles are deficient in their usual function. Many attempts are made to revitalize sexual incompetents entirely by the needle. Repeated failures have led sexually unhappy males to become disappointed, disgruntled and disgusted with the endeavors of modern science to reinvigorate them.

There is an old saying that poor diagnosis leads to improper treatment. This aphorism is most apropos in instances where the genitalia do not perform according to expectation.

Deficient vita sexualis cases are generally classified into two groups: 1. Organic or somatic impotence, in which the causative factor is material in origin, e.g., strictures, infections, tumors, etc. 2. Functional or psychic impotence. Here the cause is nonmaterial, i.e., due to improper thinking, with the consequence that the patient becomes obsessed with sexual fright. This grouping is faulty because a vast number of sexually below par males do not belong in either division. Also, there are men who regard themselves as impotent when they are entirely blameless for their inadequacy. I shall attempt to bring some order out of the state of chaos which surrounds the problem of male sexual incapacity by utilizing a more scientific approach.

If a man's sexual ability is very low because of some demonstrable lesion in the sexual organs and the degree of his impotency is made considerably worse by his constant fretting over his malady, the disability should be termed "somatopsychic sexual dysfunction". On the other hand, if the genital lesion is of a trifling nature while the neurosis constitutes the principal undermining factor to sexual health, the malady should be called "psychosomatic sexual dysfunction". Hence, if the major fault lies within the body, this fact is emphasized by placing the word "somato" first in the compound descriptive term. If the mental attitude is largely to blame for the patient's sexual dilemma, then the term "psycho" is placed first.

A category need also be reserved for those youthful subjects who are woefully ignorant of sexual physiology. These "timid souls" possess none of the fundamentals of the lover's art. These cases should be considered as "sexual dysfunction of inaptitude" or "sexual stupidity".

Revision of the field of psychically induced sexual incompetentcy is also in order. Spouses who suffer with extreme vaginismus may and frequently do render their mates sexually incapable. Two cases of vaginismus, one of five and one of nine years' standing, came to my notice. In both cases the husband was the victim of "sexual defeatism". These men believed themselves to be entirely at fault. When the vaginismus of their spouses was corrected, the potency of these men returned and they were then able to express themselves sexually in a satisfactory manner.

Masked or outright paranoia in the wife may cause the sexual undoing of the male. I was consulted by a man who considered himself sexually deficient. His history disclosed the fact that each time he attempted sexual union his wife would berate him for some imaginary misconduct. Prior to contemplated coitus she would accuse him of paying too much attention to some huzzy. At the height of the argument the husband's erection would vanish. Correct nomenclature for cases of this type would be "psychic impotence induced by sexual partner's psychoneurosis or psychosis".

Masked male homosexuality may present itself in the form of impotency. Even a physician expert in handling sexual disturbances may be baffled by the unbiological behavior of an apparently husky he-man type. These people mislead physicians by their overwhelming braggadocio concerning their erstwhile sexual conquests. Men who lead amphisextrous lives also may prove to be conumdrums unless the examining physician possesses more than average skill. Many cases on the homosexual borderline can be rescued from a miserable existence if their physician be sufficiently adroit in releasing the conflicts which torture the patient's mind. To designate this sort of sexual weakness, the label ought to read "impotence-psychical-borderline-inverted type".

One of the most trying problems which confront the medical profession is the establishment of substantial proof that a man is psychically impotent. This matter is frequently left to the courts for decision. Legal interpretation of what constitutes impotence or nullity rests on a line of pretty sound common sense logic. The balanced reasoning of a New Jersey judge in handling a case of sexual cowardice is here presented so as to illustrate the difficulties which confront the jurist as well as the physician.

> This petition is for annulment of marriage on the ground of incurable impotency. The couple, young persons, have cohabited for five years, and the wife is still a virgin. She is physically and mentally normal and capable of copulating. Her virginity and aptness are established beyond question by three physicians who examined her recently. She testified that her husband never tried to function, that he made no effort at penetration, and that the extent of his performances was to be upon her, with parts limp between her thighs, and agitate. He vigorously protested his virility, but admitted the nonconsummation of the marriage, and also that he sought gratification by external attrition as his wife described, because, as he says, his efforts at sexual intercourse were painful and distressing to her. He submitted to an examination by one of his wife's physicians, who testified that he was structurally a male, normal in the parts, and to all appearances capable of coitus. In build, carriage, voice, and deportment, as I observed him in court, he appeared to be up to the standard.
>
> If there is genital impairment, it is latent and scientifically undiscoverable; or the lapse may be due to a psychosis, well recognized in the medical science, and discussed in some of the divorce cases in England . . .

The burden then being shifted to the husband to excuse or justify the plight of his wife, the question comes to one of belief in his story of forbearance for five years, under most trying circumstances, simply because sexual intercourse was painful and distressing to her, I have misgivings. Such solicitude of a groom is noble, of a husband heroic. Few have the fortitude to resist the temptations of the honeymoon. But human endurance has its limitations, and when nature demands its due, youth is prodigal in the payment. Men are still cave men in the pleasures of the bed. The sex may be more temperate, but none the less passionate, and heedless of the penalty. They do not shirk the initiation, nor shrink from the consequences. The husband's plea does not inspire confidence. Common experience discredits it. And if, in fact, he had the physical power, and refrained from sexual intercourse during the five years he occupied the same bed with his wife, purely out of sympathy for her feelings, he deserves to be doubted for not having asserted his rights, even though she balked.

The presumption of impotency has not been overcome, and a decree of nullity will be advised.

Proper diagnosis in this case could have been easily established by a series of tests to estimate this man's degree of sexual maturity. His peculiar and asinine h havior would have been reflected in a detailed histo of his emotional life. A physician, after completion a psychological examination, could state that the su ject is or is not emotionally equipped to execute h marital obligations.

Psychic impotence, despite the mysterious aspects the affliction, is generally curable. Great sacrifices oft have to be made by the patient to obtain the objecti he seeks. Social habits need adjustment. Patterns sexual diffidence have to be scrapped. When a healt sexual attitude is established, the patient may be co sidered on his way to the goal of sexual accomplishme and sexual success. Accurate terminology applied those in sexual distress would lessen the confusion a sociated with the word "impotence". Synonyms whi serve to describe the nature of the sexual lesion shou be favored. Thus, the barrier of humility which mak disclosure of sex life difficult can be leaped.

MEDICAL ARTS BUILDING

TESTICULAR DEFICIENCY FOLLOWING VARICOCELECTOMY*

Clinical Application of Testosterone Pellets

LEO E. GRAJEWSKI
Detroit, Mich.

The clinical application of testicular hormones has occupied a prominent place in urological literature since 1849 when Berthold (1) described the injection of testicular tissue into capons with the production of secondary male characteristics as a definite clinical entity. Koch and Gallagher (2) demonstrated a method of extracting androgens from the urine by quantitative assay. Recently assays by colorimetric method have been described by Callow, Callow, Emmens (3), and Oesting (4).

Specific androgen therapy has had wide clinical application by Kearn (5), Werner (6), Dunn (7), Harding and Fraser (8), Eidelsberg, Ornstein (9), and others, with excellent results achieved by inunction, oral, sublingual, parenteral, and subcutaneous administration.

The following is a brief summary of the case presented:

A man, twenty-seven years of age, came to the clinic on July 15, 1941, complaining of pain in the right chest and the right side of the neck, of fifteen months' duration; loss of weight, ten pounds in three months; fatigue for fifteen months; night sweats for one year; anxiety and muscular weakness for eight months; hot flashes for twelve months, and loss of libido and impotency for thirteen months. This condition came on two months after a bilateral excision of a varicocele at another hospital. The physical examination was normal except for bilateral scars on the scrotum. Both testes were practically completely atrophied. Only a slight shell could be detected on the left and no definite testicle could be made out on the right. The scrotum was atrophied, prostate and penis were of normal size, a few nonmotile spermatozoa were present, and the basal metabolism rate was minus 7. Roentgenograms of the chest a cervical spine were normal.

Treatment: During the last four months, from Ju to November 1941, the patient received testosteron propionate parenterally, twenty-five mgs. every oth day, with striking improvement in his general heal and libido. On November 15, 1941, three hundred mg of testosterone pellets[1] (oreton F) were implanted su cutaneously below the angle of the scapula. Marked a tention was paid to hemostasis and asepsis. On Dece ber 1, 1941, there was noted still further improveme and a sense of well-being. Libido became stronger, ere tions were normal, and coitus was satisfactory. On D cember 18, 1942, the patient himself noticed an increa in the size of the testes and scrotum and pigmentatio On December 20, 1942, he had a hot flash, and th absence of night sweats, anxiety state and fatigue w noticed. On January 11, 1943, there was urethral di charge, and the patient admitted exposure; smear w positive for gonococcus. He was placed on sulfa therap and a second implantation of four hundred mgs. testosterone pellets was made on January 18, 194 There was prompt improvement in two days. On Fe ruary 1st he was inducted into the Army.

Summary

A case has been presented of male climacteric follow ing bilateral varicocelectomy. Physical examination the patient revealed atrophy of the scrotum and test Administration of testosterone (oreton F) pellets, im planted subcutaneously, provided adequate amounts hormone material for complete recovery.

2201 JEFFERSON AVENUE EAST

*From the Department of Urology, Alexander Blain Hospital, Detroit, Mich.

[1]I wish to acknowledge my indebtedness to the Schering Corpor tion, Bloomfield, N.J., for the generous supply of Oreton F.

[2]References appear on page 617.

Editorials

The Common Cold

Between seasons, that is in the fall and spring with the change over from warm to cold weather, and vice versa, that disturbing phenomenon known as "a cold" causes great discomfort to the common run of humanity. Some people say that they "never take cold". There may be a natural immunity and this is, indeed, a blessing, but to *acquire* immunity is exceedingly difficult. In fact, having "one cold on top of another" has become an integral part of colloquial conversation. In these days, it is popular to call every nasal disturbance "sinus". In fact sinusitis is as much talked about as appendicitis used to be. But sinusitis is one of the many complications of a cold. Few colds fail to invade the sinuses since the mucous membrane is continuous from the nasal fossæ into the reaches beyond. Every rhinologist knows that many socalled sinus infections are, in reality, manifestations of allergy, and except for the more or less constant water-logging of the nasal mucosa, especially of the turbinates, allergic symptoms are much like cold symptoms.

Therapeutic nihilists, many of them doctors of medicine, will tell you that an untreated cold lasts two weeks; while a treated cold lasts a fortnight. In other words it makes no difference what you do, the distressing symptoms so familiar to all of us remain. That is a rather extreme view. In a recent conversation a friend of mine, who is an ear, nose and throat specialist, said: "If that were true, I would have posted a sign on my door twenty years ago, to the effect that I would never be back."

There is probably a constitutional background or disordered metabolism when a cold comes on. Wet feet, drafts, and chilled body surface help to bring the crisis, but they are merely predisposing, not actual causes. It is fairly well conceded now that a filtrable virus causes the symptoms, and that the staphylococcus and other organisms are merely visitors who find the going good when the virus has broken down whatever resistance is in the tissues. There are at least three facts about the virus: First, it is highly transmissible through coughing, sneezing, kissing, or probably from fomites and eating utensils; second, any immunity established is of short duration; third, it does not, ordinarily, prostrate the patient, and, therefore, people continue to go out to public places and spread their disability to many others. If quarantine were possible, some reduction in colds might be obtained, but the only present recourse is to a campaign of education as to the transmissibility of colds. Even so, we can reach only a certain level of the population: the heedless and ignorant will prefer to remain so.

As to treatment, the nose and throat should be put into as good condition as possible. This means doing away with nasal obstruction, diseased tonsils and adenoids, polypi, deviated septi, and other abnormal conditions. The general health must be kept at the highest possible level and such conditions as anemia or gastrointestinal disorders should be corrected. Immunization, while fairly impossible, may lessen the number of attacks or minimize the virulence of them. Vaccines are thought by some to be worthless, but so many factors enter in, that a blanket indictment should not be set down. The preparation of the vaccine is important. Heat used to be the method of destroying the live organisms; now, chemical agents are thought to be preferable. Either an autogenous or a stock vaccine which has been recently made are used. The first injection consists of two minims between the layers of the skin, *not subcutaneously*. The antigens are said to work better via the intradermal route. The dosage is increased at each visit, doubled usually, and is given twice a week. At home, irrigations of normal saline every two hours wash away débris. This is best done with an ear and ulcer syringe. If the nose is stuffy, benzedrine must be inhaled first, using just enough to open the nose. After all water is removed by sucking backward and expectorating, "antiseptic drops" may be used. The patient lies on his back and introduces about ten drops of a twenty-five percent solution of hexylresorcinol into each nostril. If there is any stinging sensation, a little alkalol, a dram to the ounce, may be added. In any case, promptness in treatment makes a lot of difference. If sinus complications ensue, the course may be prolonged for weeks.

The Control of Typhus Fever

Typhus fever is a disease of cold and temperate climates and occurs in those months of the year when confinement within doors and overcrowding are most common. Epidemics are most likely to break out in times of war, for the obvious reason that conditions favoring its spread are present. Predisposing causes are infestation by verminous pests, overcrowding and malnutrition, and while an unsanitary environment is a contributory cause, overcrowding in louse-infested quarters seems to be the main cause.

Dr. J. Johnson Abraham, in a letter to the *British Medical Journal*, February 21, 1943, says it has been suggested that lack of vitamins is a major factor in the causation of typhus fever, but he is inclined to discredit the idea. He argues that lack of vitamins in winter may increase susceptibility to some extent and certainly does increase the death rate, but the main explanation of the increase, to his mind, is the huddling

together of louse-infested bodies and the rapid communication of the virus thus facilitated. He bases this view on his experience during the great typhus epidemic in Serbia in 1915. All the conditions of overcrowding were there, but there was no lack of essential foodstuffs. It was the trains crowded with refugee peasants, and the overcrowding of barracks, hospitals, and prisoner-of-war camps that allowed the disease to get a grip on the population. In their hospitals, for instance, there were four patients to every two beds pushed together. They were all louse-infested and the disease, once started, became rampant. As soon as spaces were cleared between the beds and there was no overcrowding, the percentage of new cases dropped dramatically, although the diet was the same. Their unit consisted of six doctors and twelve British orderlies, all well fed, well housed and well clothed. They lacked for nothing, yet three of the doctors and nine of the orderlies caught the disease from dressing the wounds of infected persons, and three orderlies died.

Dr. Abraham makes an important statement. He says it is probable that only louse-borne typhus occurs in Europe and the flea and tick typhus diseases of tropical countries and America do not concern those in Europe. The fact that the body louse can only crawl is therefore our main protection.

It is said that typhus fever is rare in tropical climes and in this country the disease seldom appears, which may be due, as far as the United States in concerned, to the fact that sanitation and domestic hygiene are good, as a rule. Again, for the same reason, typhus is practically extinct in Britain. It may then be inferred that the louse which crawls is the main transmitter of typhus, that close personal contact is the chief factor in disseminating the malady, and its prevention consists in maintaining conditions of cleanliness in which this louse cannot exist.

Scabies and Its Treatment

Scabies, commonly termed the itch, is caused by a spider-like acarine parasite, Sarcoptes scabiei. The parasite generally found in man is a special variety, and is not contracted from animals. Although scabies is regarded as a war problem and is believed to be more prevalent under war conditions, owing to overcrowding and lack of efficient means for keeping clean, this view is controverted by Dr. K. Mellanby, a British authority. At a symposium on ecology and the control of lice, itch mites and other parasites, held in London by the Association of Applied Biologists, Dr. Mellanby expressed disagreement with statements published frequently that war conditions, especially shelter life, were responsible for an increased incidence of scabies. Probably, there has been much more scabies in Britain recently than at any time since immediately after th last war, he said, but there was no foundation for th belief that war was the cause of the greater incidenc The reports of the Chief Medical Officer of the Englis Board of Education in 1937 and 1938 referred to a increase of scabies at a time when there was no wa and when housing and employment were improving The present epidemic of scabies, in his opinion, wa the continuation of a trend which was in existence b fore the war started. Under badly controlled condition no doubt, scabies, like other parasitic diseases, was mor readily transmitted among susceptible persons. Never theless, in towns where there had been no bombing an no shelter experience, scabies had increased in the sam way as elsewhere. The coincidence of epidemics o scabies with the periods of the last and the present wa was fortuitous.

Nor was it always the unclean persons who suffered from scabies; it was perfectly easy for persons of scrup ulous cleanliness to contract the disease, but as it wa frequently diagnosed by its secondary infections, whic were less likely to occur among clean people, the rea conditions were often missed. Here is another factor o transmission concerning which Dr. Mellanby falls fou of generally accepted views. He pointed out that it wa the common view that scabies was contracted normall by occupying beds which had been occupied just pre viously by infected persons. He had obtained the serv ices of a group of volunteers who were willing to ru the risk of infection, and conducted a series of experi ments, which demonstrated that personal contac seemed to be the most likely method of spread and con tact with inanimate objects which had been next to scabious person was not as dangerous as had bee thought. Any risk, therefore, in occupying strange bed was not high.

The foregoing opinions on this troublesome skin af fection are useful and timely, although not conclusiv on all points. However, scabies does not seem to be a infectious as was supposed, and, consequently, method for prevention not so difficult.

Commission to Study Medical Care

On September 5th Governor Dewey appointed th members of a temporary commission created by th 1944 Legislature, on his recommendation, to make th necessary studies in order to devise programs for med cal care for all groups and classes throughout the stat The aim is to provide medical care for the needy a public expense, and it is hoped that a middle groun will be found between the extreme views of those wh desire socialized medicine and those who oppose al broadening of medical care. Dr. Basil C. MacLean, o Rochester, has been appointed chairman of the con

mission and the membership includes Dr. Lucien Brown, Sydenham Hospital, New York; Dr. Robert Levy, professor of clinical medicine, College of Physicians and Surgeons, Columbia University; Dr. George MacKenzie, of Cooperstown, and Dr. Herman Gates Weiskotten, of Syracuse.

News Items

The First Harvey Lecture.—The first lecture in the 1944-1945 series presented by the Harvey Society in affiliation with the New York Academy of Medicine will be delivered on Thursday evening, October 26th, by Dr. E. Newton Harvey, Henry Fairfield Osborn professor of biology, Princeton University. His subject will be, "Decompression Sickness and Bubble Formation in Blood and Tissues".

Stated Meetings of the Academy.—The first stated meeting of The New York Academy of Medicine was held on Thursday evening, October 5th. The scientific program was arranged in cooperation with the section of surgery, and included two papers dealing with thrombophlebitis. Dr. A. Wilbur Duryea of the New York Post-Graduate Medical School, Columbia University, discussed the medical treatment, and Dr. Geza de Takats, associate professor of surgery, University of Illinois, discussed the surgical treatment.

Friday Afternoon Lectures.—The current series of Friday afternoon lectures given at the New York Academy of Medicine will be inaugurated on November 3d with a lecture by Dr. James A. Shannon, associate professor of medicine, New York University College of Medicine. His subject will be recent advances in drug therapy. On November 10th, Lieut. Colonel T. C. Thompson, M.C., A.U.S., chief of orthopedic and amputation sections, Walter Reed General Hospital, Washington, D.C., will lecture on war fractures; and on November 17, Dr. Joseph Harkavy, associate physician, Mount Sinai Hospital, will deliver an address on new concepts of bronchial asthma and treatment.

Louis Livingston Seaman Fund.—The New York Academy of Medicine announces that $1,000.00 of the Louis Livingston Seaman Fund for the furtherance of research in bacteriology and sanitary science is now available for assignment in 1944. The committee will receive applications from institutions or individuals up to November 1st. Communications should be addressed to Dr. Wilson G. Smillie, chairman of the Louis Livingston Seaman Fund, 1300 York Avenue, New York, 21, New York.

General Hospital Becomes Tuberculosis Center.—The Bruns General Hospital, in Sante Fe, New Mexico, has been designed as an Army center for the treatment of tuberculosis. This hospital, which is under the command of Brigadier General Larry B. McAfee, M.C., is specially staffed with tuberculosis experts, and utilizes the most modern equipment and methods of treatment. Bruns General Hospital was named in honor of Colonel Earl Harvey Bruns, M.C., who was one of the most distinguished phthisiologists in the history of the Army.

Medical Society of Virginia.—The ninety-sixth annual meeting of the Medical Society of Virginia will be held in Richmond, October 23d, 24th, and 25th, under the presidency of Dr. C. B. Bowyer, of Stonega. Among the guest speakers will be Dr. Alexis F. Hartmann, professor of pediatrics at Washington University, St. Louis, and Dr. Wallace E. Herrell, consultant in medicine at the Mayo Clinic, Rochester, Minn.

Flight Surgeons' Assistants.—A class of forty flight surgeons' assistants completed the six weeks course in aviation medicine at the School of Aviation Medicine, Randolph Field, Texas, on July 29th. These men were trained as specialists in assisting flight surgeons in the selection, care and maintenance of the flier. Brig. General Eugen G. Reinartz is commandant of the school.

Medical School Opened in Newark, N. J.—The Essex College of Medicine, said to be the first institution of its kind in New Jersey, was opened in Newark on October 1st. The facilities include an auditorium, twenty-five classrooms and a laboratory. For the first four years only one hundred students are to be accepted. The State Board of Education has ruled, however, that the school cannot issue the degree of Doctor of Medicine until it had been in existence two years.

Poliomyelitis Among U.S. Troops.—It is reported that during the two weeks ending September 2, 1944, twenty cases of poliomyelitis were reported by Army installations in the United States, which represents a slightly higher incidence than for the corresponding period last year. The total incidence since the first of the year is somewhat lower than in the corresponding eight-month period in 1943.

American College of Chest Physicians.—The second annual meeting of the Southern Chapter of the American College of Chest Physicians will be held conjointly with the Southern Medical Association in St. Louis, Mo., November 13th to 16th. Headquarers will be the De Soto Hotel. An interesting program has been arranged and there will also be x ray conferences held at the De Soto Hotel in connection with the meeting. Dr. Paul A. Turner, of Louisville, Ky., is chairman of the scientific program committee and Dr. H. I. Spector, of St. Louis, has been appointed chairman of the committee of arrangements.

American College of Surgeons Cancels Annual Meeting.—Dr. Irvin Abell, of Louisville, Ky., chairman of the Board of Regents of the American College of Surgeons, has announced the cancellation of the 1944 clinical congress which was to have been held in Chicago, October 24th to 27th. This action was taken because of the great demands upon the transportation systems for carrying wounded military personnel, troops, and war material. This is the third successive year that the American College of Surgeons has cancelled its annual meeting in order to aid the war effort. The Board of Regents will meet later in the year, however, when fellowships in the College will be conferred *in absentia* on the class of initiates of 1944, as there will be no convocation exercises. At the same time the list of hospitals, cancer clinics, medical services in industry, hospitals conducting programs of graduate training in surgery, and medical motion pictures, that meet the College standards, will be approved and later published. All present officers, regents, governors, and standing committees will continue in office.

Personal.—Major Frank A. Mantz, M.C., of Cynwyd, Pa., has been appointed chief of the Malaria Control Section in the Preventive Medicine Service, Office of the Surgeon General. Major Mantz has been stationed overseas as malariologist for the past three years, lastly in the China-Burma-India theater to which he was assigned early in January 1943.

Dr. Louis Dublin, second vice-president and statistician of the Metropolitan Life Insurance Company, has been appointed assistant to Mr. Basil O'Connor, chairman of the American Red Cross Central Committee. Dr. Dublin has been given a leave of absence from the Metropolitan for a limited period, and will devote his entire time to Red Cross duties.

Brig. General Edgar Erskine Hume was recently awarded the Oak Leaf Cluster to the Distinguished Service Medal in recognition of his service as chief of the Allied Military Government Section, Fifth Army, in Italy. General Hume received the Distinguished Service Medal for his outstanding service as a medical officer during the first world war as commissioner of the American Red Cross after the war in Serbia.

Dr. Millard C. Hanson, of Richmond, Va., has been appointed medical director of the American Red Cross, in charge of the Pacific area, with headquarters in San Francisco. Dr. Hanson will have charge of the medical activities of the Red Cross in seven western states and the territory of Alaska.

Dr. James Bryant Conant, president of Harvard University, was presented with the Priestley Medal at the 108th annual meeting of the American Chemical Society, held last month in New York.

Dr. C. W. M. Poynter, professor of anatomy and dean of the College of Medicine of the University of Nebraska, was honored on the occasion of his sixty-ninth birthday with a banquet sponsored by alumni association of the college. More than three hundred friends, former students and associates of Dr. Poynter attended, and others sent congratulatory messages. The toastmaster was Colonel E. V. Allen, M.C., U.S. Army.

Dr. Philip S. Platt, who has had wide experience in the administration of public health and social welfare institutions, has been appointed executive director of the New York Association for the Blind, at the Lighthouse, 111 East Fifty-ninth Street, New York.

Dr. Carlos Estevez, former director general of Sanitation of Guatemala, has joined the Pan-American Sanitary Bureau for the study of filariasis. His headquarters will be in Mexico. The United States and Mexico are studying means of eradicating the disease in Central America.

Major Alfred Golden, M.C., Madison, Wis., who has been on duty for the past four years at the Army Medical Museum, has been transferred to the Division of Health and Sanitation, Office of the Coordinator of Inter-American Affairs, and will be assigned to duty in Latin America to study the pathology of certain tropical diseases.

Major M. E. DeBakey of the Surgery Division, Office of the Surgeon General, and Major Leon H. Warren, M.C., chief of the Research Coordination Branch, Technical Division, were recently promoted to the rank of Lieut. Colonel.

Dr. Jerome A. Marks, formerly of 145 West Fifty-Eighth Street, New York, announces the removal of his office to 121 East Sixtieth Street, New York 22, N.Y.

Postgraduate Course in Venereal Disease Cotrol.—The U.S. Public Health Service's eighth po graduate course in venereal disease control will be co ducted at the Public Health Service Medical Cente Hot Springs, Ark., October 19th to November 8th. TH course which will be given to health officers and to pr vate physicians cooperating with state and local heal department venereal disease control programs, consis of lectures and demonstrations presented by outstan ing specialists. Among those who will conduct th course are Dr. Udo J. Wile, Ann Arbor, Mich.; L Ruth Boring Thomas, New York; Dr. Austin V. Dei ert, Fort Douglas, Utah; Dr. Richard C. Arnold, State Island, N.Y.; Dr. Eugene A. Gillis, New Orleans, La and Dr. Robert B. Greenblatt, Hot Springs, Ark. A plications for admittance to the course should be su mitted promptly through State health officers, to th Medical Officer in Charge, U.S. Public Health Servi Medical Center, Hot Springs National Park, Ark.

Infantile Paralysis Situation Improving.—T peak of the 1944 epidemic of infantile paralysis for th nation as a whole apparently has been passed, and th incidence of the disease is now tapering off, accordi to the latest reports received by The National Foundh tion for Infantile Paralysis. The heaviest incidence cases for the nation occurred in the week of Septemb 2d when 1,683 cases were reported to the U.S. Publ Health Service. The week of September 9th showed drop to 1,487, and reports since then from epidem states indicate the decline is continuing. The total f the year up to September 9th was 10,959 cases, or mo cases for the comparable period than at any time sin America's worst epidemic year in 1916. This year's t tal for the first thirty-six weeks is 2,030 cases high than for the same period in 1931, which to date is th second highest epidemic year.

In combatting the epidemic, the National Found tion has sent out seven doctors, fifty physical ther pists and more than seven tons of wool as well as eme gency financial relief. The American Red Cross h recruited approximately seven hundred nurses to su plement local facilities in epidemic areas. All twent six of the respirators owned by the National Found tion are still in active use, it is reported.

Refresher Courses in Venereal Diseases.—T New York Health Department announces a twel session refresher course in venereal diseases to given on Saturday mornings in the Health Departme building, 125 Worth Street. These courses are d signed to afford New York City physicians an oppo tunity to keep abreast of new developments in syph lis and gonorrhea therapy. Specialists in these diseas will lead the discussions and whenever possible p tients will be presented. The first lecture was given September 30th, and the subject discussed wa "Changing aspects in treatment of venereal disease Subjects for other lectures are as follows: Octob 7th, Penicillin treatment of sulfonamide-resista gonorrhea in the male; October 14th, Penicillin trea ment of sulfonamide-resistant gonorrhea in the male; October 21st, Treatment of complications in th male and female; October 28th, Rapid treatme methods for early syphilis; November 4th, Ambul tory treatment of early syphilis; November 18t Cerebrospinal syphilis; November 25th, Office labor tory procedures.

UNITED STATES AIDS LATIN AMERICAN MEDICINE

R. J. BEHAN

President, Pan American Cooperative Foundation

Pittsburgh, Pa.

A physician visiting in Latin America will find rather interesting relationships. He is apt to enter the countries of Latin America believing that the physicians of these countries are not as up-to-date and advanced as the physicians of the United States. In this he is likely to find himself greatly disillusioned, because I found that the doctors of Latin America are up-to-date and progressive. The leading doctors have all had postgraduate medical training, and it deflated my national ego when I learned that most of the physicians native to Latin America until recently had been receiving their medical education in their homeland and traveling for their postgraduate studies to France and Germany. Some I found had been to Spain, but only a few had traveled to the United States. However, owing to the present eclipse of French and German medicine, the trend of postgraduate medical education has been toward the United States.

This tendency is encouraged by our government in cooperation with the governments of Latin America. The United States State Department, in coordination with the Institute of Inter-American Education, as well as the Coordinator's Office, is granting subsidies and scholarships to many Latin Americans. These scholarships permit them to take comprehensive courses in higher medical education at suitable schools and universities in the United States.

I was agreeably surprised with the progressive program of the Mexican government which is attempting to introduce a combination education and sanitation program into rural Mexico. To some extent it is successful, even though in many instances it has met with active opposition from the Indian villages. Three thousand medical students have been enrolled in the University of Mexico alone, besides great numbers in other medical schools of the country. These students are subsidized. As part payment for government support, they, after graduation, must spend a specified time in field work in the rural districts.

I found the good neighbor policy injecting itself into the development of medical activities in Guatemala, where United States government funds are supporting the development of a quinine plantation. It is claimed that one million quinine trees will be producing this year, which is really good news, for most of the available quinine supply was appropriated by the Japs when the yellow hordes overran the islands of the southwestern Pacific.

In Guatemala City I also ran across another United States sponsored project, the contemplated building of a three hundred bed general hospital. I hope the project will be completed.

The U.S.A. is well regarded in Latin America. The citizens are friendly and cooperative. Visitors from the United States are well liked. After the war I am sure American doctors will welcome the opportunity to study in Latin America those phases of medicine that are best exemplified in tropical and semitropical countries. It would not be wise again to allow ourselves to become isolated from our southern neighbors.

I found so much of medical excellence in Latin America that I wondered why more doctors of the United States have not taken advantage of their opportunities to study in these countries. Perhaps the difficulties of travel and governmental restrictions due to the war may explain their lack of interest. Travel restrictions have been eased to facilitate the entrance of Latin Americans seeking postgraduate medical education in the United States of America.

I found that many young Latin American doctors were holding medical fellowships in the U.S.A. There were 136 from June, 1939, to June, 1942. Public health fellowships numbered fifteen. From May 1, 1940 to June 30, 1942, 514 physicians and members of their allied professions in Latin America have visited the United States in contact with the Pan American Sanitary Bureau.

The scholarships granted by the Pan American Sanitary Bureau to Latin American doctors carry certain requirements which are essential. For instance, the applicant must be a citizen by birth of an American republic. He must have completed his essential training in his own country, and on coming to the United States must preferably select courses that are not offered in his own country. He must be recommended by the authorities of the university at which he studied, have a health certificate and a chest film, a thorough knowledge of the English language, and must agree to return to his country upon completion of his scholarship, and he must have the approval of national health authorities of his country. The scholarships are for one year.

In 1941 there were sixty such scholarships given to citizens of Latin American countries. This type of scholarship is not contributed entirely by the United States, for many Latin American countries are offering similar scholarships to citizens of sister republics.

6082 Jenkins Arcade

Testicular Deficiency Following Varicocelectomy

(*Continued from page 612*)

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Book Reviews

Human Constitution

Human Constitution in Clinical Medicine. By GEORGE DRAPER, M.D., associate professor of clinical medicine, College of Physicians and Surgeons, Columbia University; C. W. DUPERTUIS, Ph.D., physical anthropologist, Constitution Clinic, Presbyterian Hospital, New York, and J. L. CAUGHEY, JR., M.D., associate in medicine, College of Physicians and Surgeons, Columbia University. New York: Paul B. Hoeber, Inc., Medical Department of Harper and Brothers, 1944. Pp. 279. Price $4.00.

This delightful monograph on the relationship between each individual and his disease, latent or manifest, concerns the nature of the man within the patient. In the effort to assess an individual's capacity to meet the stress of life various methods have been devised for analyzing his component parts in order to put them together into the concept of John Doe. These procedures have dealt with morphological, psychological, immunological and physiological characters, all embodied in this constitutional approach to disease. The methods used are the anthropometric technique of Martin, the photographic somatotyping technique of Sheldon, electrocardiogram, spirogram and psychological procedures in an effort to catch the essence of personal identity so jealously guarded by the eternal mask of expression. But man is so complex in origin that his totality can only be approached satisfactorily by component parts. And this authentic work gives the clinical method of approach so essential in everyday practice.

Text Book on the Inner Ear

The Inner Ear. Including Otoneurology, Otosurgery, and Problems in Modern Warfare. By JOSEPH FISCHER, M.D., staff member, Beth Israel Hospital, Boston; and LOUIS E. WOLFSON, M.D., Tufts Medical School, Boston. With seventy-nine illustrations. New York: Grune and Stratton, 1943. Pp. 421. Price, $5.75.

This excellent book stands almost alone in its comprehensive study of the anatomy, physiology and general clinical significance of the inner ear. Hitherto, foreign texts, particularly French and German, have played a lone hand. Much of this knowledge has been translated into English, but the material is scattered and not readily accessible. The subject matter is of great importance, not only to the otologist, but also to the neurologist and to the flight surgeon. Dr. Fischer had years of experience in the Vienna clinics, where much that is now known about the labyrinth had its origin. Bárány, Neumann, Alexander and Ruttin are all dead, but they gave much to otology and neurology in their time. Those were the days in the early nineteen hundreds when the world was relatively at peace, and scientific study in Europe was favored by governmental authority. *O tempora, O mores!* What hath man wrought?

The basic facts are here set down in the first two chapters. Then "applied physiology" is considered under such headings as vertigo, spontaneous nystagmus, conjugate deviation, and labyrinthine strabismus. Seven varying reactions are recorded, beginning with "optokinetic", continuing with the caloric and galvanic and turning tests, and ending with tonic reflexes and reactions. Functional tests occupy chapter 5 and include spontaneous, induced and abnormal reactions. There are chapters on chemotherapy, facial palsy, neoplasm, Ménière's syndrome, and congenital diseases affecting the inner ear. Chapter 13 considers war trauma, and following immediately is a dissertation on the rôle of the inner ear in aeronautics. The final section has to do with the effects of atmospheric pressure changes upon the labyrinth of airmen and includes "regulations for the examination of flyers." At the end of each chapter there is an extensive bibliography—in fact, nothing seems to have been left out of this volume which is likely to become "standard" in its field. The publishers, too, are to be complimented on an excellent example of bookmaking.

Amputation Stumps

Cineplastic Operations on Stumps of the Upper Extremity. By RUDOLF NISSEN, M.D., New York, and ERNST BERGMANN, M.D. New York: Grune and Stratton, 1942. Pp. 88. Price $3.75.

The background for this work seems to have been carried on chiefly in Europe, especially in Germany and in Turkey (Istanbul). The authors define "cinetization" as a practical utilization of an amputation stump by various prostheses to make the muscles which remain, effective beyond their original function. They rightfully say that improper amputations make the use of stumps impossible, and that the surgeon should have an eye for possible use of whatever remains. There are many illustrations to show how this has been done, particularly as to the upper arm. On page 60 there is a clear reproduction of a letter written by a patient (in German) who was wearing an artificial hand. The entire prosthetic procedure is too difficult to be detailed here, but surgeons in the armed forces ought to understand it thoroughly in order to give the mangled soldiers a chance to make a living. Let us hope that a better word can be found for a praiseworthy effort. "Cinetization" is ugly and conveys no meaning to the eye or ear.

Pediatric Gynecology

Pediatric Gynecology. By GOODRICH C. SCHAUFFLER, A.B., M.D., assistant clinical professor of obstetrics and gynecology, University of Oregon Medical School. Chicago: The Year Book Publishers, Inc., 1942.

A neglected field has been brought to the fore by one versed in both pediatrics and gynecology. It arose from the author's experience in treating a girl of three with gonorrheal vaginitis. The hazy status of our knowledge not only of pathological conditions in this field but our lack of knowledge of the normal anatomy and physiology and developmental processes led to the preparation of this monograph. It presents special methods of examination and discussion of the external genitalia, vagina, vaginitis, adolescent disorders, pelvic viscera, surgical and proctological disorders. The content and methods of presentation are so clear and concise that one is appreciative of the tremendous amount of material crammed into a small book when faced with a gynecological problem in a young child. The diagnostic procedures are practical and the therapeutic armamentaria extensive. While more emphasis is given to surgical than to medical methods there is considerable orientation material invaluable in pediatric practice. Even medical legal aspects are given in connection with some of the problems considered. The book is an invaluable adjuvant for practitioner and pediatrician alike and is beautifully printed and presented.

Phenomena of Physics

Physics Tells Why. An Explanation of Some Common Physical Phenomena. By Overton Luhr. Illustrated by Ruth C. Schmidt. Lancaster, Pa.: The Jaques Cattell Press, 1943. Pp. 318. Price $3.50.

With his rich cultural background and his many scientific interests, the late author had a unique ability for making the complex and obscure phenomena of physics especially clear and simple to his students. It is thus not strange that in the long days of enforced rest he should have turned his efforts to expressing his thoughts about physics in the language that the young student and the interested layman could easily follow. The book which resulted is, therefore, a tribute to his love for physics and his interest in its popular and correct promulgation. To have accomplished successfully what so many have failed to do in the writing of a sound, interesting, inspiring and scholarly popular book for the layman without the use of the terrifying mathematics which characterizes physics was a proper culmination of a fine scientific career. The book is interestingly and charmingly written. Its function of explaining in a simple fashion so many of the phenomena puzzling to the man in the street and the housewife in her kitchen is ably achieved. This book, written as it was from the sick bed, was Professor Luhr's last contribution to his beloved physics.

Infections of Mediastinum

Acute Infections of the Mediastinum. By Harold Neuhof, M.D., F.A.C.S., clinical professor of surgery, Columbia University, and Edward E. Jemerin, M.D., F.A.C.S., associate attending surgeon, Sydenham Hospital. Baltimore: The Williams and Wilkins Company, 1943. Pp. 407. Price $6.00.

The material in this book should be of considerable interest to clinicians as well as persons specializing in diseases of the chest and radiotherapy. There are four groups of infections of the mediastinum considered: The first, those secondary to trauma; the second group, those infections resulting from upper respiratory infections; the third group, those secondary to infections of the lung and pleura, and a forth group dealing with miscellaneous etiology. The presentation is quite complete and well illustrated with x rays. While the subject is extensive, we feel the subject matter is thoroughly covered and well presented.

Fatty Acids and Lipids

Biochemistry of the Fatty Acids and Their Compounds, the Lipids. By W. R. Bloor, professor of biochemistry and pharmacology, The University of Rochester, N.Y. American Chemical Society Monograph Series No. 93. New York: Reinhold Publishing Corporation, 1943. Pp. 387. Price $6.00.

This is one of the most complete monographs on the subject we have encountered. It covers the field primarily from the angle of the chemist but at the same time enters into the field of biology and medicine. Much work has been done on the fatty acids but there are still many problems remaining unsolved. This book of Bloor's gives an extremely comprehensive picture of what has taken place to date in the study of the lipids. Of particular interest are the chapters on digestion and absorption, lipids of the blood and tissues, and the metabolism of lipids, and the chapter that deals with their secretions and excretions in various parts of the economy. We are sure many physicians will welcome this book and make use of it either in part or read it diligently if they are especially interested in the subject.

Dermatology in General Practice

Dermatologic Therapy in General Practice. By Marion B. Sulzberger, M.D., assistant clinical professor of dermatology and syphilology, and Jack Wolf, M.D., attending dermatologist and syphilologist, New York Post-Graduate Medical School and Hospital of Columbia University. Chicago: The Year Book Publishers, Inc., 1943. Pp. 632.

There is, to my knowledge, no available text in which a special and well considered effort is made to lay before the student and practitioner a clearly written, easily understood and precise treatise in which are detailed only those elements of the management of the "commoner" skin diseases and syphilis which will prove practical and useful to every physician. In this book the authors have succeeded in presenting such a treatise. Brief as the individual chapters are, they nevertheless set forth sufficiently complete and accurate directions and descriptions to enable the practitioner readily to apply without further reading and delving into references, the most approved and the safest methods of present-day dermatosyphilological therapy. For those who desire further information, the authors append the more important references.

It seems obvious to me that the patient with a cutaneous disease, as well as the one with syphilis, will generally fare best when treated by the specialist; but it is equally obvious that we cannot expect all patients with these diseases to receive the benefit of immediate specialistic care. Whether this desideratum is in the offing is a subject demanding serious thought and earnest discussion. The objective of this book, therefore, is to describe as fully and completely as possible those procedures and medicaments which every physician can promptly apply in the management of the common skin diseases. The authors are to be commended especially on their judicious selection of topics. They refrain from discussing the many unusual and rare dermatoses which the nonspecialist will not encounter with regularity and which he cannot be expected to recognize and treat. Even in the discussion of the management of the common skin diseases, the authors have avoided descriptions of methods not generally available to physicians who do not possess the special equipment and paraphernalia of the dermatosyphilologist.

Thus the book embraces information on the dermatological and antisyphilitic therapy which all physicians can profitably use and which any physician can apply; it omits details which are often burdensome and useless. By such omission of the rare dermatoses and of specialistic discussions which are necessarily included in complete textbooks, the authors have succeeded in presenting, in a happily complete and precise fashion, step-by-step directions for the writing of prescriptions, the use of various medicaments and the application of practical measures which they recommend. The result is a book which certainly deserves a niche for itself. It is calculated to supply the practitioner with all possible assistance in the management of eighty to ninety percent of the skin diseases he may be called upon to treat. Moreover, I feel that not only the nonspecialist but also students and beginning practitioners of dermatology and syphilology will find the book useful and instructive; for the authors have set forth with clarity and accuracy that which is still the essence of the practice of medicine—namely, rules and procedures of management, the direct steps to be taken in the effort to relieve the patient's complaints.

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OCTOBER 1944

Medicolegal Notes

Infection Held "Accident"

Reviewing many cases on the meaning of the word "accidental", in an insurance policy insuring against injuries effected by "accidental means", the Washington Supreme Court, Zinse vs. Equitable Life Insurance Co. of Iowa, 107 P. 2d 921, adheres to the line of cases which hold that death is accidental, within the meaning of such a policy, where death occurs as the result of unusual, unexpected or unforeseen events following an intentional act, provided that those events are not normally effected. The question in this case was whether death is accidental within the meaning of such a policy where an operation is performed and an incision intentionally made, the usual precautions taken to prevent infection, and no mishap occurs during the operation, germs enter from without through the incision and result in septicemia, the entry of the germs being entirely unforeseen, unusual, unexpected and unintended.

The incision made, the court said, was not uncommon. Infection follows only on rare occasions. In this case, although the incision which afforded a channel of entry for the germs was intentionally made, the entry of the deadly germs was not normally effected but was wholly unintentional, unforeseen and unexpected, and, the court held, "it was the admission of those germs, rather than the intentional act of the doctor, which caused the death. The infection itself was as much an accident as though the insured had been struck by an automobile and killed on his way to the hospital. The germs came from the outside into the incision, and the actions were more deadly and vicious than many visible instruments of violence." The insured's death was therefore held to be accidental under the policy.

Excessive Damages Remitted

In an action against a druggist for damage for negligently filling a prescription with the wrong drug, using atropine instead of eserine, which was used in a boy's eyes, the wrong drug having a greater effect on the eyes than the prescription otherwise would have had, it was held that there was substantial evidence that the plaintiff was suffering from a disease at the time of the trial and that the use of the wrong drug aggravated this disease; so that the defendants were liable for negligence.

But it was held error in the trial court to instruct the jury on punitive damages, in the absence of any evidence of wantonness on the part of the defendant. The jury was not asked to find how much of the damages was for actual damages or how much was for punitive damages. It was held that under the circumstances this error could be cured by the appellate court's ordering a remittitur, so that the judgment need not be reversed on that account.

The jury found for the plaintiff in the amount of $15,000. The trial court ordered a remittitur of $7,500 of this verdict, or a new trial. The Kansas Supreme Court, on appeal, further held that under all the facts and circumstances the verdict of $7,500 was excessive and the plaintiff was ordered to remit $2,500 of it or have a new trial. Bocck vs. Katz Drug Co., 127 P. 2d 506, 155 Kan. 656.

Statute of Limitation Applies to "Irregular Practitioners"

In an action against a pharmacist for personal injuries caused allegedly by defendant "negligently, recklessly, carelessly and without proper training therefor, equipment or qualification", applying an instrument to the location of a swelling on plaintiff's hand, causing an incision to be made and exposing subcutaneous tissue, the New York Appellate Division, Rudman v. Bancheri 260 A.D. 957, 23 N.Y.S. 2d 584, said that under the facts alleged in the complaint the defendant was practicing medicine as defined in the Education Law although not qualified or licensed as a physician. "Recovery may be had in such an action as this only if the defendant's treatment of the plaintiff fell short of the professional standards of skill and care prevailing among those who offer treatment lawfully. The allegation in the complaint that the defendant 'failed to exercise the care, caution and prudence in the premises' with injurious results, classifies this action as one in malpractice, against which the limitation of the statute, Civil Practice Act, 50, has run."

The court cited Monahan vs. Devinny, 223 App. Div. 547, 229 N.Y.S. 60, where it was held that the term "malpractice" applies to irregular practitioners as well as nurses, midwives and apothecaries. Adel, J., dissented on the authority of Isenstein vs. Malcolmson, 227 App. Di. 66, 236 N.Y.S. 641, where the contrary view was expressed.

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The most frequent indication for estrogenic therapy is the menopause syndrome. Because of the chromicity of the syndrome of this transitional period, maximum symptomatic relief with a minimum of hazard to the patient is the most important attribute of a clinically preferred hormone preparation.

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Here is a preparation of naturally occurring estron and other natural hormones as they occur in the urine of pregnant mares, standardized in International Units by established assay methods and suspended in sterile oil at various dosage levels. Sherman Estrogenic Hormone has an enviable record of therapeutic value, proved by extensive clinical employment.

Of paramount importance is the demonstrated fact that the employment of the mixed natural estrogens usually results in the creation of a feeling of general well being, not just a cessation of isolated symptoms*. Also, unlike artificial hormone preparations, the natural estrogens seldom produce toxic side effects.

*Weisbader & Kurzrok, Endocrinology: 23; 32; 1938.

Sherman Estrogenic Hormone is available in concentrations of 2000 and 10,000 International Units per c.c. The 2,000 I. U. preparation is available in 1 c.c. ampuls and in 30 c.c. vials. The 10,000 I. U. preparation is available in 1 c.c. ampuls and 10 c.c., 20 c.c. and 30 c.c. vials at most good prescription pharmacies or can be ordered direct.

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Critique

Food or Drug? In 1929 the *Chemist and Druggist* of London was trying to find the answer to a problem that still agitates New York—are vitamins food or drugs? In the old days the line was clear, but after vitamins and minerals were found to have definite health-giving properties, so much so that deprival resulted in illness, things changed. While few would say that irradiated ergosterol is a food, it may well be regarded as an accessory food factor and the same substance, found in egg yolk, for instance, is certainly a part of a food, a very integral part, too. The London journal also remarked: "When irradiated ergosterol with a little orange juice is added to malt extract, it makes it resemble two or three palatable preparations which are certainly regarded as foods. Palatability or unlimited freedom in taking may not be a guide; but the decision whether a given product is food or medicine is frequently arbitrary and not due to reason or commonsense."

Bunk in Clinical Lab Reports? An editorial in the *Journal of Laboratory and Clinical Medicine,* March 1929, inspired by Rockwood, Reed, and Myers in *J.A.M.A.* 91:157-167, 1928, remarked there was then bunk in clinical laboratory work and reports. Technicians were used too extensively as time savers. "Routine" or "complete" tests were requested by doctors who had no full knowledge of what this meant or implied. Special blood counts and blood chemistry examinations, the icterus index, cholesterol, calcium, carbon dioxide-combining power, and so on, were requested on the theory tha... a diagnosis would somehow happen accidentally. Clin... cal work was often ordered before the patient had ... physical examination. Yet "the average physician ... practice will not see more than ten or a dozen case... a year in which a chemical analysis of the blood wi... be of any value to him in diagnosis or treatment," a... cording to one doctor quoted. A "routine blood chem... istry" is a meaningless term; it reflects ill upon th... diagnostic ability of the physician using it. The type... of cases in which abnormal blood occurs can be pre... dicted with considerable accuracy. Some rules set u... were: Never get the nonprotein nitrogen and the ure... on the same patient; never ask for nonprotein nitroge... when the phenolsulphonephthalein secretion is norma... except in an emergency; only use uric acid determina... tion in suspected gout; order the blood sugar don... only in suspected diabetes or hypoglycemia; order th... blood calcium only in tetany of unknown origin; us... inorganic phosphorus tests only for rickets or infan... tile tetany, and so on. Myers held we needed mo... biochemists rather than more clinicians. He said "a... though the help of technical assistants in a hospit... laboratory is almost indispensable, such help is pos... tively dangerous unless the work is under the directio... of someone with competent chemical training". Th... clinician should be thorough and should know th... meaning of laboratory procedures and ask for specif... tests and not for nonessential data: he should be a... sured that his highly specialized biochemical work ... done by and under direct supervision of competen... persons. This reminds the CRITIC that physicians in ... Greater New York hospital told him not long since tha... laboratory and clinical work was at such a low ebb...

Through The Menstrual Years of Life—

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective tonic and regulator in the practicing physician's armamentarium.

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May we send you a copy of the comprehensive booklet "The Symptomatic Treatment of Menstrual Irregularities."

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because of poor personnel in wartime, that they paid little or no attention to it and found they got along about as well without it. Physicians who have been with the armed forces under perilous conditions have also told the CRITIC that they found it possible to operate with great success medically and surgically in complete absence of more than two-thirds the drugs, laboratory tests, clinical records, and instruments they regarded as indispensable at home. So what?

Food and Intelligence

To what extent does a full stomach tend to guarantee a sound mind? Is heredity determined by victuals? The *Nation* of April 3, 1929, quoted Dr. John Munroe of Long Island University as saying, after a sixteen-year experiment with more than five thousand school children, seven hundred of whom were followed on into college and later life: "Intelligence is not constant, nor is it entirely hereditary. Much of the present shortage in intelligence may be alleviated when it is recognized that the physical and chemical surroundings of the germ plasm prior to birth may hopelessly condition that plasm into idiocy after birth; that the expectant mother probably does require food and health care for the developing embryo in order to produce children of high intelligence; that the vicious food conditions, the sanitation and hygiene, the brutality of many homes appear to be the conditioners of moronity and borderline dullness; and that rapidly developing intelligence must be stimulated on all levels incessantly if it is to come to full development." Today in wartime the people of the United States are better fed, and a larger percentage of them have adequate diets, than ever before. Can this be depended upon so to enhance mass intelligence that we shall be able to prevent a future resort to mass destruction of human life and property as a preliminary to the solution of international difficulties?

Basic Research

In *Science* for March 29, 1929 E. M. Freeman of the University of Minnesota wrote on this subject. Institutions pressed for practical results often feel it incumbent to neglect the fundamentals. "Our greatest experiment station the United States Department of Agriculture, and probably one of the greatest institutes for fundamental research in the work, is honeycombed with shafts of basic research. The field of bacteriology owes a tremendous debt to the outstanding researches of the late Erwin F. Smith and his coworkers. Can there be any question of the fundamental nature of these investigations? The work of the Wisconsin Experiment Station in its fundamental attack on the relation of temperature to plant diseases would reflect credit on any institute for fundamental research. The Minnesota station, cooperating with the Cereal Office of the United States Department of Agriculture, has sunk deep the shaft of physiological forms in the study of rusts of wheat. The minute and difficultly measured differences in infection behavior of rusts from various sources have required years of patient research, apparently far removed from the field of application. Yet these results have not only proved of primary importance in the breeding of wheats for rust resistance, but they have also brought about a profound change in the fundamental methods of attack in the investigations of plant diseases all over the world.—THE CRITIC.

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relieves the various vasomotor and nervous disturbances so frequent at the menopausal period, with uniformly good results.

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More than so-termed tonics and restoratives, Ovaltine can materially shorten the period required for the return of strength and vigor following recovery from infectious or prolonged illnesses. During the acute stages of febrile diseases, when the patient's nutritional intake is low, while requirements are higher than normal, many metabolic deficits are developed. These can be made good only by a high intake of essential nutrients during the recovery period, for only after these nutritional deficits are wiped out can former strength and well-being return.

Ovaltine offers many advantages as a nutritional supplement to the diet of convalescence. This delicious food drink is rich in needed minerals, vitamins, and biologically adequate proteins. Its appealing taste invites consumption of three or more glassfuls daily. Its notably low curd tension encourages rapid gastric emptying, an important factor in maintaining good appetite.

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	Dry Ovaltine	Ovaltine with milk*		Dry Ovaltine	Ovaltine with milk*
PROTEIN	6.0 Gm.	31.2 Gm.	VITAMIN A	1500 I.U.	2953 I.U.
CARBOHYDRATE	30.0 Gm.	62.43 Gm.	VITAMIN D	405 I.U.	480 I.U.
FAT	2.8 Gm.	29.34 Gm.	THIAMINE	.9 mg.	1.296 mg.
CALCIUM	.25 Gm.	1.104 Gm.	RIBOFLAVIN	.25 mg.	1.278 mg.
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*Each serving made with 8 oz. of milk; based on average reported values for milk.

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The result of these tests, together with other informative data, will be mailed to interested physicians on request.

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The Use of Sulfated Oil as a Skin Cleanser in the Management of Acne Vulgaris

Swartz and Blank (*J.A.M.A.* 125:1:30-31 (May) 1944) report their experience with the use of a sulfated[1]-oil preparation, Acidolate, in the management of acne vulgaris. For the past four years, they routinely prescribed Acidolate as the cutaneous detergent for patients affected with acne vulgaris. Observations cover over four hundred cases in private practice and many cases in the dermatological clinics at Harvard Medical School and the Massachusetts General Hospital.

The authors state that acne vulgaris is almost invariably characterized by an overactivity of the sebaceous glands and a resultant abundance of oily secretion on the skin surface. They point out that the regular and relatively complete removal of this oily secretion is an accepted therapeutic principle.

The rationale for the use of Acidolate is outlined. The preparation is described as a modern cleansing agent of the sulfated-oil type, designed primarily for use in the management of dermatological conditions in which soap is contraindicated. It contains vegetable oils "solubilized" by treatment with concentrated sulfuric acid, therefore miscible with oil and water alike; thus these solubilized oils emulsify dirt and oil on the skin surface and yield to removal when the skin is rinsed with water. The cleansing process—emulsification and rinsing—is latherless.

The reader is cautioned not to confuse sulfated-oil with sulfur soap. Sulfated-oil contains little or no free sulfur, and cannot supply the action of free sulfur. Various sulfated-oils differ in chemical composition, some possessing by-products of manufacture which may irritate the skin. The authors have not found a single case of facial dermatitis following the use of Acidolate in their cases of acne vulgaris.

Attention is called to the necessary instructions given for the proper application of Acidolate. The patient is told to pour a small amount of the oil into the palm of the left hand, and to apply the oil to the unmoistened skin of the face by rubbing with the fingers of the right hand, as though applying a cream. This facial massage is performed for several minutes and followed by a thorough rinsing with plenty of warm water. Thus, oil, dirt and cosmetics are thoroughly removed. The cleansing operation is performed three times a day in the beginning; as the skin manifests a decreased oil secretion, cleansing is repeated less frequently.

The authors describe three general types of acne vulgaris, namely, the juvenile, the papulopustular, and the indurated; for all three, the following treatment is recommended:

1. Cleansing with Acidolate and subsequent application of borated alcohol after each cleansing.
2. Mechanical expulsion of comedones.
3. Regulation of the diet, whereby chocolate, nuts and cooked fats are eliminated.

Removal of comedones is preceded by thorough cleansing with Acidolate and the application of borated alcohol; the latter is also applied after removal. The patient is shown how to use the comedo extractor and told to perform the removal twice a week, sterilizing the extractor by boiling before each use.

The juvenile type of acne vulgaris usually responds satisfactorily to this therapy. It seems that fewer com-

[1]The term "sulfated" and "sulphonated" are sometimes used interchangeably although "sulfated" is correct.

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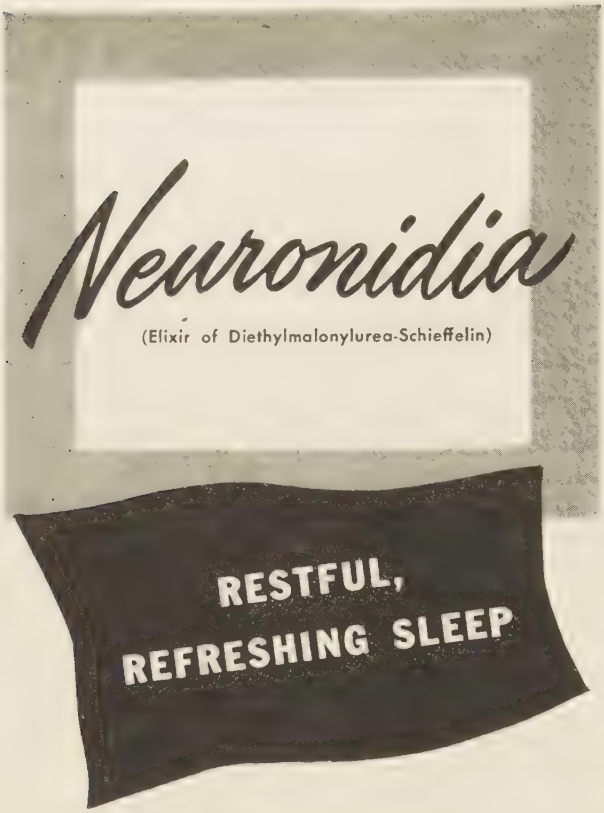

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dones are formed and that they may sometimes be moved by the cleansing process alone.

In the papulopustular type, it may be necessary add ultraviolet irradiation to the therapeutic plan, to prescribe a shake lotion for use at bedtime. For tients of light complexion, and for patients whose is not very oily, the shake lotion consists of calam 4 Gm. or cc.; zinc oxide, eight; phenol, two; glycer eight; spirit of camphor, four, and distilled wate 240; for patients of dark complexion and for case excessive oiliness of the skin, the lotion is made "r drying" by the inclusion of precipitated sulfur, e Gm. or cc. and alcohol, one hundred and twenty. type of acne has responded better to the use of sh lotion plus Acidolate cleansing than to shake lotion cleansing.

The indurated type frequently requires radia with x rays, especially when it responds too slowl routine measures; during the period of radiation th py, sulfur shake lotions and other irritating prep tions should be discontinued; following radiation x rays, cleansing with Acidolate and the applicatio the first mentioned shake lotion are recommended.

Meningitis in Children

R. Gross-Heisler and Eli Davis, of St. Andr L.C.C. Hospital (*British Jour. Child. Dis.*, April-J 1944) report six cases of meningitis in children ref tory to sulfonamides. There were two cases suprarenal hemorrhage, one of which had meningo cal meningitis, and four cases of streptococcal staphylococcal meningitis. The treatment with sul amides was useless. The patients all died.

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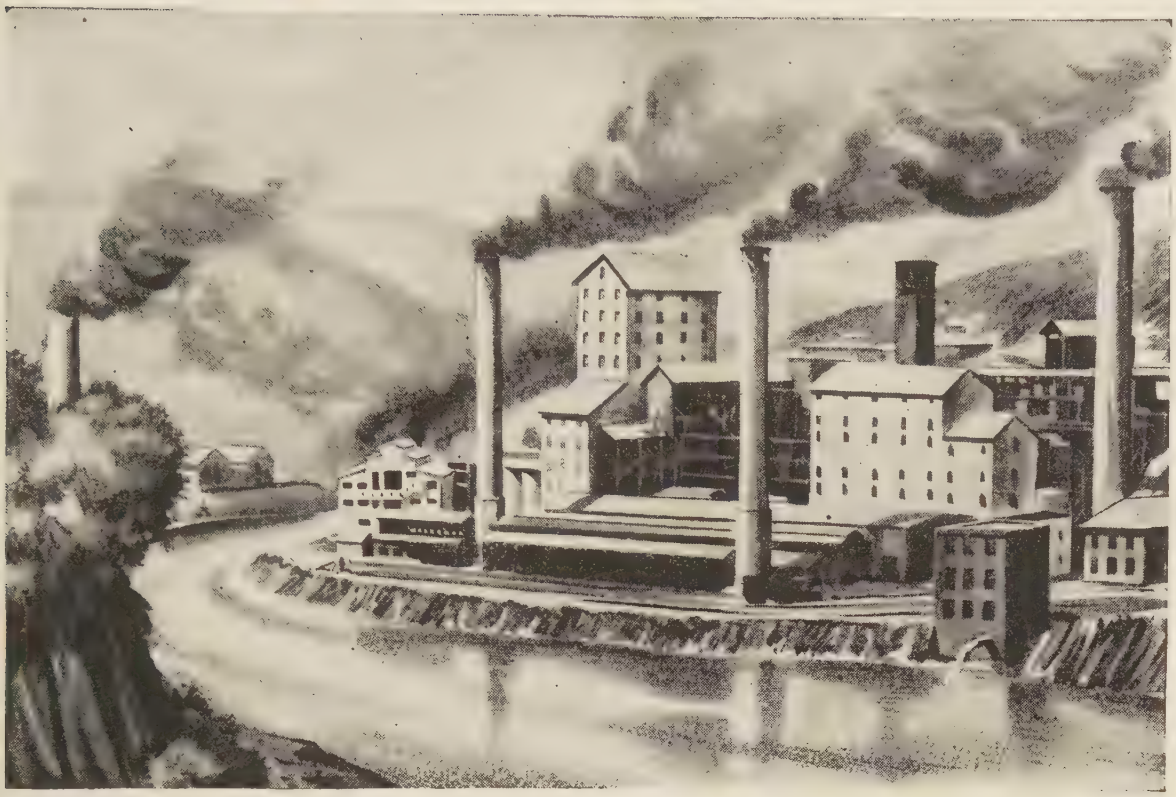

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Similarly, in the intestinal tract, there is no more efficient method of evacuating waste than by the use of *liquid bulk*—as formed by Sal Hepatica plus water.

Clinical and laboratory tests prove that:

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Liver Disease and Life Insurance

At the American Life Convention, held in Chicago last June, Dr. Carlo J. Tripoli, director of the Helis Institute for Medical Research and formerly professor of medicine, Graduate School of Medicine, Louisiana State University, New Orleans, La., read a paper on the differential diagnosis of liver disease. Dr. D. Schuyler Pulford, assistant medical director of California-Western States Life Insurance Company, Sacramento, in discussing this paper, said that Dr. Tripoli had presented a clear cut picture of the possibilities of the more modern and accurate diagnosis of liver diseases, in the light of certain laboratory tests and physiological principles. He pointed out the possibilities of a more liberal life insurance underwriting attitude towards certain types of liver ailments in the years ahead when liver function tests will be used extensively in thousands of cases, with a resultant better general knowledge of what to expect from applicants with a history of liver disease. Under the present underwriting principles applied to liver disease, life insurance rating manuals call for the rejection of applicants that indicate a history of cirrhosis of the liver, hepatomegalies, tumors and all other serious liver diseases. He contended that little concerted action had been taken in the consideration of liver disease, and thought that applicants for large amounts of life insurance should be persuaded to take a liver function test. He referred to the time when a history of tuberculosis automatically prevented an applicant from obtaining life insurance. "Now the life cycle of those patients has been reviewed in large enough numbers over a long period to appraise these risks properly and they are offered insurance."

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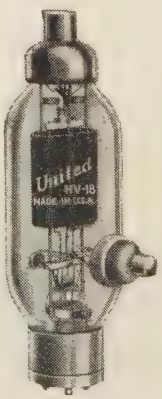

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Hypertension, regardless of the cause, leads to death from cardiac decompensation in 60% of cases. The *height* of blood pressure readings is an extremely important factor in the prognosis of this insidious disease. Studies reveal that mortality increases in direct proportion to the elevation of blood pressure above the normal.

HEPVISC is a peripheral vasodilator that lowers systolic and diastolic pressures to more secure levels. This desired action is produced gradually and safely. Moreover, the beneficial effect of HEPVISC persists for some time after the medication has been withdrawn.

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Formula:

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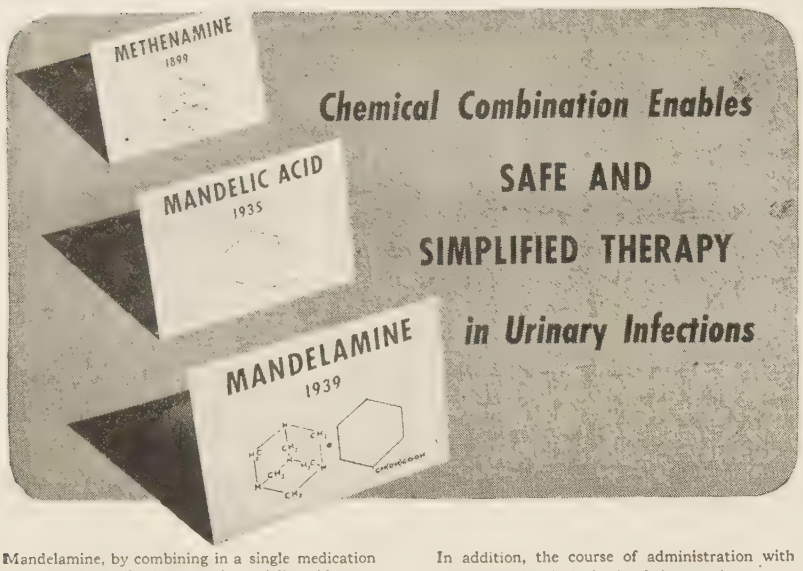

Mandelamine, by combining in a single medication the recognized effectiveness of mandelic acid as an acidifying agent and the efficiency of methenamine as a bactericidal agent, offers the physician a safe and simplified method of treatment for urinary infections.

Gastro-intestinal disturbances, so common with other urinary antiseptics, are virtually eliminated when Mandelamine is used. It is especially valuable in the treatment of pyelitis of pregnancy, where its easy toleration does much to avoid aggravation of the nausea and vomiting often associated with the gestatory period. Other conditions for which Mandelamine is indicated are pyelonephritis, cystitis, prostatitis, and the infection accompanying renal calculi.

In addition, the course of administration with Mandelamine is relatively simple inasmuch as accessory acidification of the urine, constant checking of the urinary pH, and the restriction of diet and fluid intake are generally unnecessary.

We suggest that you try Mandelamine in your practice so that you may observe its many advantages both to you, and to the patient.

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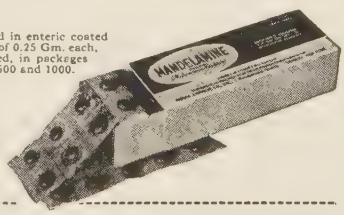

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Physical Therapy Clinic in the Jung

A physical therapy clinic was cr ated recently out of makeshift ma rials by members of a hospital unit the Ledo Road, the highway whi Allied troops are building from A sam, India, through Burma to Chi against the vigorous opposition of t Japanese. Lieut. Colonel Willis N Weeden, U.S. Medical Corps, Woodbury, Conn., chief of surgery the unit, assigned Captain Hyman Stein, of Elkins Park, Pa., and Se ond Lieutenant Pauline Moud Army Nurse Corps, of Alhambr Calif., to the task. They made a d heat apparatus out of a crate and ele tric bulbs. Stirrups with ropes an weights made weight lifting devices. Chinese officer provided a bicycle fr leg exercises and old gasoline tan were turned into whirlpool leg an arm baths. A water heater was cr ated from a gasoline drum and t hard rubber core of an old soft ba was used for hand and finger exe cises.

Drug Supply Depots Established in Eight Major Ports

The War Shipping Administratio recently announced the establishmen of drug supply depots in eight maj ports, which will assure a supply essential drugs for men in the Amer can Merchant Marine. Supplies penicillin, dried blood plasma, inse ticides and quinine will be maintaine in depots at the ports of New Yor Portland, Ore., Seattle, New Orlean Norfolk, Va., Baltimore, San Fra cisco and Philadelphia. This will en able the operators of all WSA owne or chartered vessels to maintain rea ily a supply of essential medicines a prescribed in the minimum drug lis Preparations such as these are not a ways available in quantity on th open market.

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1. Simons, D. J., and Wolff, H. G.: Med. Clin. N. Am., Phila., W. B. Saunders Co., p. 440-441, 1944.

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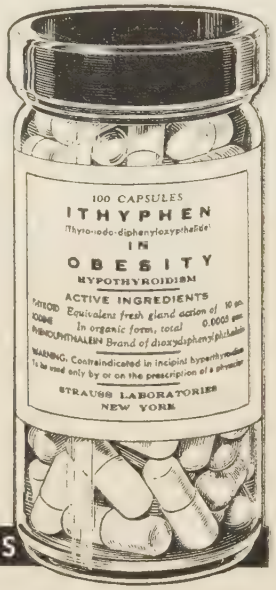

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Diet and Climate

An intensive study of diet and climate and the effe on humans is being conducted by the University of I linois with the Colleges of Medicine, Agriculture, E gineering, and Liberal Arts and Sciences cooperatin As a part of this research tests were made on twelv volunteers to determine the effects of diet upon huma resistance to cold and on human activity under col conditions. It is believed that the knowledge obtain from these tests will be of special value to high flyi military aviators, and will also apply to Army and Nav activities in the Arctic region and to winter outdo workers in the northern United States, Canada an Alaska.

The purpose of the experiments reported was to d termine the effect upon the resistance to cold of mod fying the proportions of the three food elements—pr tein, carbohydrate, and fat—in the diet; also include was the effect of meals at shorter intervals. Meals hig in carbohydrates—starches and sugars—or in fats we found to be valuable in reducing the decrease in bot internal and surface body temperatures, and in redu ing the effect of cold upon the coordination of nerv and muscles.

Eating three small meals at two-hour intervals du ing an eight hour period of exposure to the intense col instead of one larger meal in the middle of the perio was found to increase the benefit of the diets. Compa ing the least favorable diet of one high-protein me during the eight hour cold exposure period with th best diet of three high-fat meals during the period, th research showed that the decrease in internal bod temperature was reduced by two-thirds and the d crease in nerve-muscle coordination reduced one-hal

The tests were conducted by Dr. R. W. Keeton, the University's College of Medicine, and Professor H H. Mitchell, of the College of Agriculture. Professor M K. Fahnestock of the College of Engineering planne and supervised the apparatus. Assisting were fiftee other doctors, engineers, physiologists, psychiatrist dietitians, and nutrition experts of the university staf The research was done in the Educational and Re search Hospital of the University's College of Medicin at the Illinois Medical Center. The project was carrie on with the cooperation of the Committee on Medica Research of the U.S. Office of Scientific Research an Development.

Heinrich Koebner has accredited to him as Koebner's d sease what we know as Epidermolysis bullosa hereditar (1866). Koebner also reported one of the first recognize cases of xanthoma.

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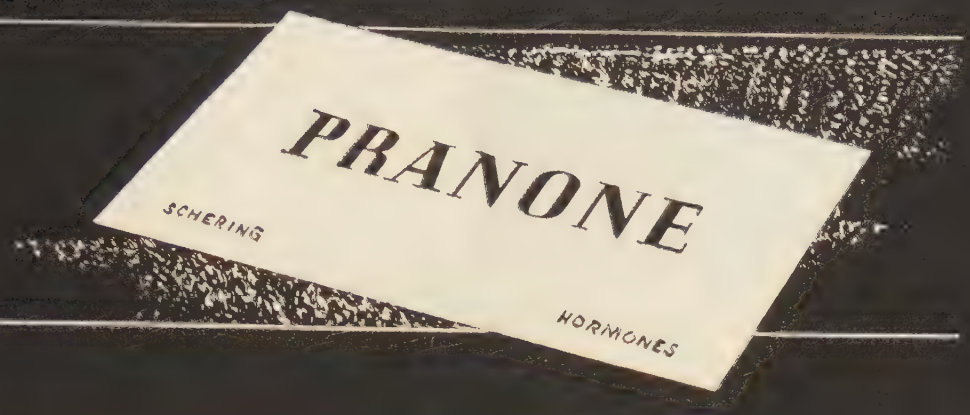

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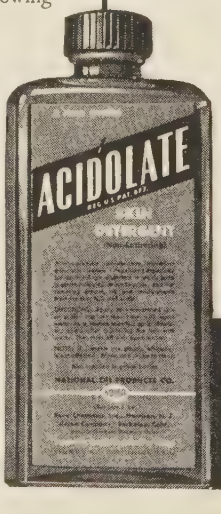

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Cancer of the Lung

In an article on the incidence a prevalence of cancer of the lu (*Public Health Reports,* August 1943) Harold F. Dorn, United Sta Public Health Service, says that b tween 1914 and 1930 the death ra from cancer of the lungs and pleura creased 3.7 times compared with increase of twenty percent for forms of cancer combined. The dea rate from cancer of the lungs a pleura continued to increase fr 1930 to 1940.

It is estimated that between 45 000 and 500,000 persons in the Unit States are under medical treatme for cancer, and approximately twen thousand of these cases have a pri ary cancer of the respiratory syste and of these about thirteen thousa are being treated for primary can of the lung.

Slightly more than eight thousa new cases of primary cancer of t lung are diagnosed and receive me cal treatment for the first time ea year. Nearly five thousand additio cases with primary cancer of the o er parts of the respiratory system a also diagnosed, making a total of a proximately thirteen thousand n cases of primary cancer of the respir tory system which are given medi care for the first time each year.

Surgical Operating Trucks Take Hospital to Wounded Soldier

The Army Medical Departme has established mobile surgi groups, which provide hospital faci ties for wounded soldiers near t front lines. The tent is carried on two-wheel trailer along with an ele trical generating unit; the hospi vehicle can be made ready for f operation within thirty minutes. Su ficient room is provided for operati

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d men a day. The truck is equipped
h a variety of special instruments
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ial and brain surgery; operating
les, steam and dry sterilizers, light-
equipment, medicines, blood
sma, bandages and dressings, rec-
l files, auxiliary power unit, sur-
al linens and operating gowns.

Ovid's Dermatocosmetic Axioms

Ovid told the men of his day:
eanliness pleases, let others per-
ire. He gave these directions: Your
ngue should not be coated, and
ur teeth should be gleaming. You
ould avoid a bald head [he didn't
l how] and keep your locks from
ing sticky. Skillfully trim your locks
d beard. The fingernails should be
pt clean, and evenly trimmed. The
istles in your nose should not pro-
ıde.

Ovid said to the ladies: The women
e their hair with German herbs, and
e artificial color is better than the
tural. They come and go decorated
th false hair which they purchase to
ver their own age worn crowning
ory. Nor do they hesitate to use
uge. They wish to appear like as
n be to the younger women who
ırade about the temple of Hercules.
Hide the tricks of your beautify-
g arts. It is offensive to see evi-
ences of powder too thickly applied,
of ointment spread to excess. Keep
seclusion while in the midst of your
eautifying activities, for though such
ctions may serve well, it is not pleas-
g to watch their application.—From
ne published work of Dr. Herman
oodman.

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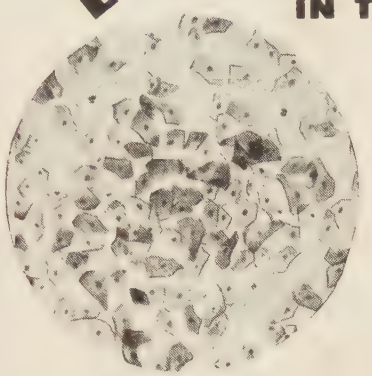
IN THE MENOPAUSE



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The recommendation was based on the results of an intensive study made by the Commission of 1,128 dementia praecox patients treated with insulin shock therapy at the Brooklyn State Hospital in five and a half years and a comparable group of 876 patients admitted to state hospitals in the metropolitan area who did not receive that form of treatment. The report stated th the insulin treated patients did substantially better all respects than the nontreated patients. It was fou that 79.5 percent of the insulin treated patients were a to leave the hospital, as against 58.8 percent of t nontreated group, and after a shorter stay. At the e of the study, between five and a half years and months after release, 58.9 percent of those who h received the shock treatment were at home, compar with forty-four percent not so treated. More than ha or fifty-five percent of the insulin patients, were use members of the community, in contrast to 40.5 perce of the nontreated patients. Many were earning th

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ving, and some were getting along better than before ey became ill.

To put the findings into effect the Commission recmmended that the State Department of Mental Hyene make the new treatment available to all dementia raecox patients, unless they are not eligible for it for hysical or other reasons, "unless and until other forms f treatment have demonstrated still better results".

The Commission recommended that to secure a consistent use of insulin therapy throughout the State hosital system a consulting service be established in the tate Department of Mental Hygiene to assure adeuate records, to hold consultations with hospital staffs in the interest of high standards of treatment, to make follow-up studies, and to provide special courses at the State Psychiatric Institute and Hospital for training personnel to administer the treatment.

Members of the Commission include Dr. Lawrence Kolb, Assistant Surgeon General, U.S. Public Health Service; Dr. Nolan D. C. Lewis, director of the New York State Psychiatric Institute and Hospital; Dr. Frederick W. Parsons, former State Commissioner of Mental Hygiene; Dr. William L. Russell, consulting psychiatrist, Payne Whitney Psychiatric Clinic; and Dr. George S. Stevenson, Medical Director, National Committee for Mental Hygiene.

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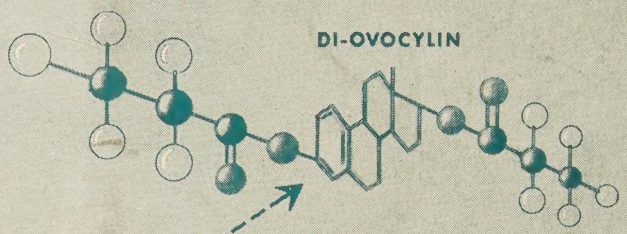

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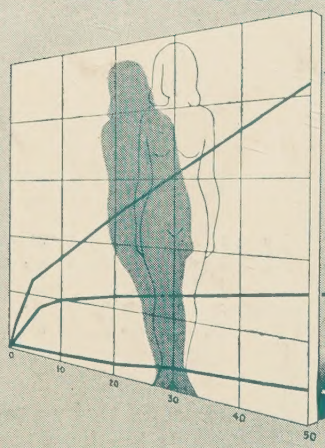

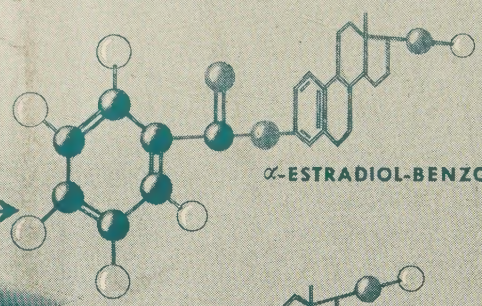

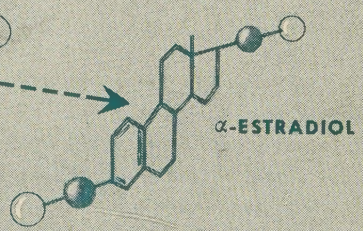

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